

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 3 1 1 5 4 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FLORENCE VEIRS ABERT					12-28-79				
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Female		White		6-8-89		90 YRS.		6:00 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		1 Dale Dr.				Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1 Dale Dr.	
Md		Mont		Rockville					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST		MIDDLE		LAST		FIRST		MIDDLE	
Charles				Veirs		Rose		Lyddane	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT		
NO					215-48-0234		Rose Williams (daughter)		
							308 Falls Rd Rockville Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a).									
Cardiac arrest									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerotic cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Diabetes mellitus									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	
NONE								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
					P.M. 19			NONE	
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK								STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 3, 19 64, to Dec 28, 19 79, that (I) (we) last saw the deceased alive on Dec 20, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
Stephen C. Cromwell, M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			12-28-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Stephen C. Cromwell, M.D.					615 W. Montgomery, Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION	
BURIAL			12-31-79		St. Mary's Cemetery			Rockville Md.	
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
NAME Robert A. Pumphrey, Funeral Homes, P.A., Bethesda, Maryland					JAN 4 1980				



RECEIVED
JAN 11 1964
U.S. AIR FORCE
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP _____

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 1 5 5

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alexander E. Aikens, Jr.			2r. DATE OF DEATH MONTH DAY YEAR 12.12.79			2b. HOUR 12 15A M	
3 SEX Male	4 RACE Colored	5 DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1923	6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Consultant		12b. KIND OF BUSINESS OR INDUSTRY Science		
13a. STATE New York		13b. COUNTY	13c. CITY OR TOWN Chappaqua	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 238 Mill River Road	
14 FATHER'S NAME FIRST MIDDLE LAST Alexander E. Aikens, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Davis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 028-12-5976		17 INFORMANT ADDRESS (Mrs.) Helen Davis 89 Walnut Ave/ Mass. Boston,			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Cardiac arrest</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>acute posterior myocardial infarct</u> (c) <u>2 hrs.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>12/11</u> 19 <u>79</u> , to <u>12/12</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Marvin Wadler</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/12/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARVIN WADLER</u>		22e. ADDRESS <u>8218 WISC. AV. BETH. MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12/15/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Vine Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Plymouth, Mass.</u>	
24 FUNERAL DIRECTOR NAME <u>John F. Bolden</u>		ADDRESS <u>7400 Ga. Ave., N.W.</u>		25a. DATE RECD. BY REGISTRAR <u>DEC 18 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 31156									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER E ALEXANDER									
2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR		2c. DATE ESTIMATED		MONTH DAY YEAR	
12 11 1979		11 19 79		11 11 1979		11 11 1979		11 11 1979	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE OF BIRTH	
M		W		1593		85		1593	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. DATE OF DEATH	
Maryland		U.S.A.		WIDOWED		Montgomery		11 11 1979	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14. KIND OF BUSINESS OR INDUSTRY		15. DATE OF DEATH	
Silver Spring		Holy Cross Hosp		Letter Carrier - P.O. Mailman				11 11 1979	
16a. STATE		16b. COUNTY		16c. CITY OR TOWN		16d. INSIDE CITY LIMITS?		16e. STREET ADDRESS	
Md		Mont		Silver Spring		YES		1113 Brantford Rd	
17. FATHER'S NAME		17. MOTHER'S MAIDEN NAME		18. ADDRESS		19. ADDRESS		20. ADDRESS	
Andrew Jackson Alexander		Susan Beegly		1113 Brantford Ave		Silver Spring, Md		Silver Spring, Md	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. ADDRESS	
No		213-44-2016		Edward J. Alexander		Silver Spring, Md		Silver Spring, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute Myocardial Dis.									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Chronic Myocardial Dis.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.									
None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21. DATE OF OPERATION		22. DATE OF OPERATION	
None				YES		NO		None	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		WHILE AT WORK		STREET CITY OR TOWN COUNTY STATE	
		P.M. 19				NOT WHILE AT WORK			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		MEDICAL EXAMINER		DATE SIGNED	
J. P. Rogers, M.D.		M.D.		Dec 11, 1979		MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
				Burial		Dec 14, 79		Hillcrest Burial Park	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. LOCATION		25d. COUNTY	
NAME ADDRESS		DEC 14 1979		Anthony Delaney		Cumberland Allegany Maryland		COUNTY STATE	
Silcox-Merritt Funeral Service, Cumberland, Md									

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 1 5 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Margaret Naomi Allemong			2a. DATE OF DEATH MONTH DAY YEAR December 31, 1979			2b. HOUR 11:33pM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 19, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY West Virginia				13c. CITY OR TOWN Berkeley Springs		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST W. Clarence Yost				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fara Ellen Ambrose			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-28-6857		17. INFORMANT ^{ADDRESS} The Medical Record The Clinical Center, NIH, Bethesda, Md			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 6 days 3 Years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Thalamic tumor with brainstem compression Staph pneumonia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that XX (this hospital) attended the deceased from 19 November, 19 79, to 31 December, 19 79, that (we) lost saw the deceased alive on 31 December 79, and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph R. McClellan, MD				22c. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md 20014		22e. DATE SIGNED 1/1/80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/80		23c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Berkeley spgs., w. va.	
24. FUNERAL DIRECTOR NAME Roy L. Dawson		25a. DATE REC'D. BY REGISTRAR JAN 8 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

1001 D. 1111
R. P. D. 1111

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Item #1 Film G538 12/27/79 re

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

3 1 1 5 8

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HARRIETT M. H. ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR 12 11 79		2b. HOUR 10⁴⁵ A	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 17 18		
6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC.		8. CITIZEN OF WHAT COUNTRY? USA		
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Teacher		12b. KIND OF BUSINESS OR INDUSTRY Schools		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13b. STREET ADDRESS 4105 Byrd Court,		14. FATHER'S NAME FIRST MIDDLE LAST Samuel F. Hildebrand		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Claudia Chailleux		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-24-5514		17. INFORMANT ADDRESS Frank O. Anderson-husband-(same as 13a)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma esophagus DUE TO, OR AS A CONSEQUENCE OF (c) 31 days					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22. I certify that (I) (the hospital) attended the deceased from 11-20 19 79 , to 12-11 19 79 , that (I) (we) last saw the deceased alive on 11-19 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.				
22b. SIGNATURE Edward J. Richards M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-11-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward J. Richards, MD		22e. ADDRESS 10301 Georgia Ave., S.S. Md. 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-1979		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.		24. FUNERAL DIRECTOR NAME Walter E. Pumphrey, Inc.		25a. DATE REC'D. BY REGISTRAR DEC 17 1979		
25b. REGISTRAR'S SIGNATURE Clark E. White		26. ADDRESS 8434 Ga. Ave., S.S. Md.				

Clark & Co.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

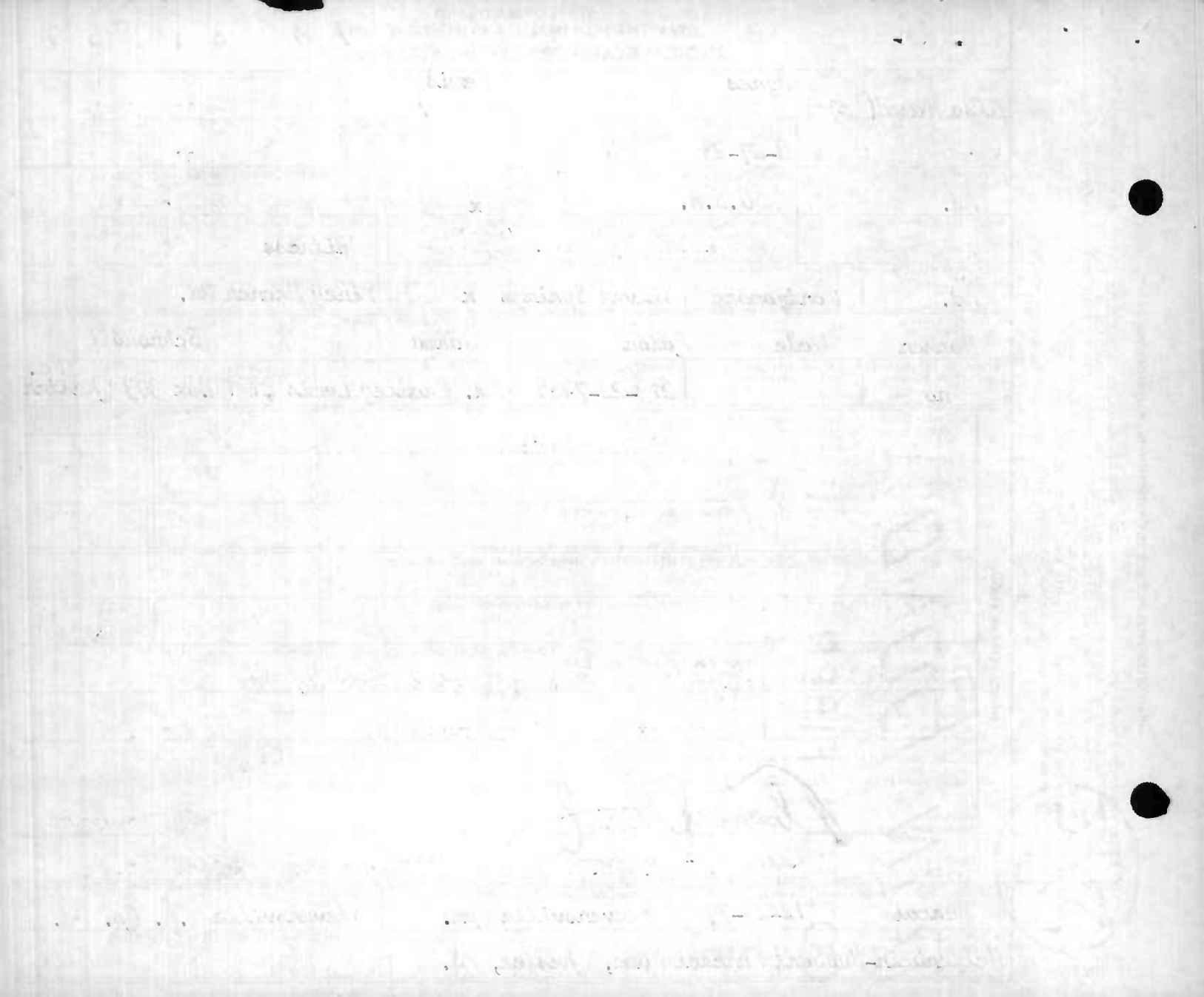
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Agnes</i> MIDDLE <i>Anderson</i> LAST <i>Lewis</i> <i>Also Named (Helen)</i>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>12 20 19 79</i>		2b. HOUR M <i>6:25P</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8-29-28</i>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>51</i>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital (DOA)</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waitress</i>
13a. STATE <i>MD.</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Springs</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Norman Wade Eaton</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Norma Schnohoff</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>213-22-7484</i>		17. INFORMANT ADDRESS <i>Mr. Bradley Lewis Rt #1 Box 303 Chester MD.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple injuries</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>8147</i> (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR <i>5:42 P.M. 12 20 1979</i>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>pedestrian struck by auto</i>		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>street</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Piney Branch Rd. Mont. MD</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>Thomas D. Smith</i>		TITLE (SPECIFY) <i>Deputy Chief</i>		DATE SIGNED <i>12/21/79</i>
EXAMINER'S NAME (TYPE OR PRINT) <i>Thomas D. Smith, M.D.</i>		ADDRESS <i>111 Penn St. Balto., MD.</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12-23-79</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Stevensville Cem.</i>		23d. LOCATION. CITY OR TOWN COUNTY STATE <i>Stevensville Q.A. Co. Md.</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Helfenbein-Hubbard Funeral Home, Chester, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 27 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Harry McCreedy</i>

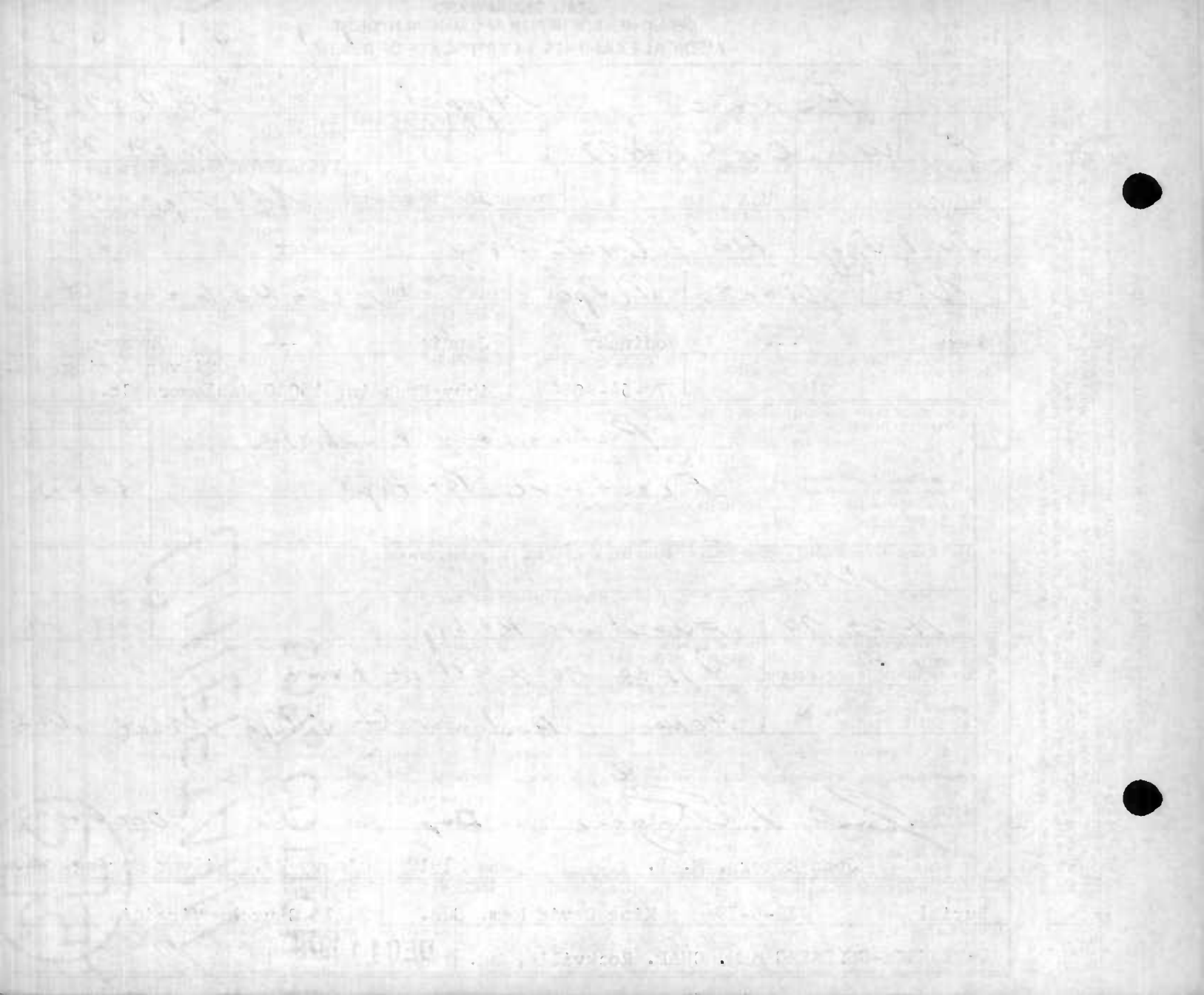


1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

31160

1. DECEASED NAME (TYPE OR PRINT) Fannie			2a. DATE KNOWN OF DEATH ESTI- MATED Dec 4 1979			2b. DATE OF DEATH MONTH DAY YEAR Dec 4 1979		
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Dec 6 1940 78 YRS.	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD Dec 4 1979		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Sr. L Spg.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY Mont. CITY OR TOWN Sr. L Spg.			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 15026 Haslemere Ct.			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel --- Wodinsky			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie --- Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 579-54-8084		17. INFORMANT Libby Epstein		ADDRESS Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Fracture Rt. Hip DUE TO, OR AS A CONSEQUENCE OF (c) 888- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None								
19a. DATE OF OPERATION 11-29-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Rt hip					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11 29 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) fall at home				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Haslemere Ct. Sr. L Spg. Mont. MD				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John Rogers		TITLE (SPECIFY) D-yr		MEDICAL EXAMINER		DATE SIGNED Dec 4 1979		
EXAMINER'S NAME (TYPE OR PRINT) John Rogers, M. D.		ADDRESS 1919 Seminary Rd., Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-79		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia		
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.				25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE [Signature]		



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR - STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR 12- 29- 79		2b. HOUR 1:38PM _M	
1. DECEASED NAME (TYPE OR PRINT) Barbara V. Ashbrook		3. SEX Female		4. RACE Cauc.	
5. DATE OF BIRTH MONTH DAY YEAR Aug. 12 1941		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STREET ADDRESS 16900 Old Colony Way	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST Harold W. Venners		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabel Craze		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 309-44-2147		17. INFORMANT James L. Ashbrook (Same as 13c)		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SHOCK</u> <u>5712</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>spontaneous bacterial peritonitis</u> (c) <u>Alcoholic Liver Disease</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Upper Gastrointestinal Bleeding 2° esophagitis and gastritis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>48 hours</u> <u>> 10 yr.</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (this hospital) attended the deceased from <u>Dec. 22</u> , 19 <u>79</u> , to <u>Dec. 29</u> , 19 <u>79</u> , that (2) (we) last saw the deceased alive on <u>Dec. 29</u> , 19 <u>79</u> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Frank J. Mayo, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <u>12-29-79</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frank J. Mayo</u>		22e. ADDRESS <u>16220 Frederick Rd. Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>12-31-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crematory Alexandria</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Va.</u>		24. FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey Funeral Homes,</u> <u>P.A., Bethesda, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 4 1980</u>	
25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 1 6 2	
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH				2b. HOUR					
Herbert						Auerbach						2a. DATE KNOWN OF DEATH				2b. HOUR					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR					
Male		White		Jan. 4, 1919		60 YRS.		MONTHS DAYS HOURS MIN.		12/13 1979				3:50 A.M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
NEW YORK				U.S.A.								Montgomery County MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring				9727 Mt. Pisgah Road, #603								ACCOUNTANT				FLORIST					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9727 Mt. Pisgah Road, #603									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME											
NATHAN										ROSE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
YES										WW II		DOROTHY C. AUERBACH, same as # 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
(b) <u>chronic myocardial disease.</u>										Years											
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
None																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?									
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
				P.M. 19				None													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION													
								CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED													
John S. Rogers, M.D.				Deputy				12/13/79													
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
John S. Rogers, M.D.				1919 Seminary Road				Silver Spring, Montgomery, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Burial				12/16/1979		BETH DAVID CEMETERY				ELMONT											
										CITY OR TOWN COUNTY STATE											
										NEW YORK											
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE													
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				DEC 17 1979																	
232 CARROLL STREET, N.W., WASHINGTON, D. C.																					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. IF DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE. IF DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD BE NOTIFIED BY TELEPHONE.

BP
DHMM - 17
(VR A15 ME (5))
30M 7/73

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH				2b. HOUR									
Giovanni						Avon						DATE ESTIMATED				MONTH DAY YEAR									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR									
male		W		11 24 03		76 YRS.						Dec 23 19 79				5:05 PM									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH									
GERMANY						U.S.A.						NEVER MARRIED				Montgomery MD									
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring Md						Holy Cross Hosp Silver Spring Md						TILE SETTER													
13a. STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS?							
MD						Montgomery						Silver Spring						YES NO							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						13e. STREET ADDRESS													
MARCELLO						AVON						ERMINIA						LIZIER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT						ADDRESS							
NO						578-05-8096						MADDALENA F. AVON						SAME AS 13 WIFE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I DEATH WAS CAUSED BY:																									
IMMEDIATE CAUSE (a)																									
4291 A cute Myocardial Dis.																									
DUE TO, OR AS A CONSEQUENCE OF																									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																									
(b) Chronic Myocardial Dis.												Yrs													
DUE TO, OR AS A CONSEQUENCE OF																									
(c)																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																									
None																									
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?													
None												YES NO													
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
						HOUR A.M. MONTH DAY YEAR																			
						P.M. 19																			
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION													
												CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																									
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED													
John S. Rogers						M.D. Dep.						Dec 23, 1979													
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS																			
JOHN S. ROGERS						1919 SEMINARY ROAD, SILVER SPRING, MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY													
BURIAL						12/27/79						GATE OF HEAVEN													
23d. LOCATION						23e. DATE REC'D. BY REGISTRAR						23f. REGISTRAR'S SIGNATURE													
SILVER SPRING						DEC 26 1979						Montgomery MD.													
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE													
FRANCIS J. COLLINS						DEC 26 1979						R. J. Collins													
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																									

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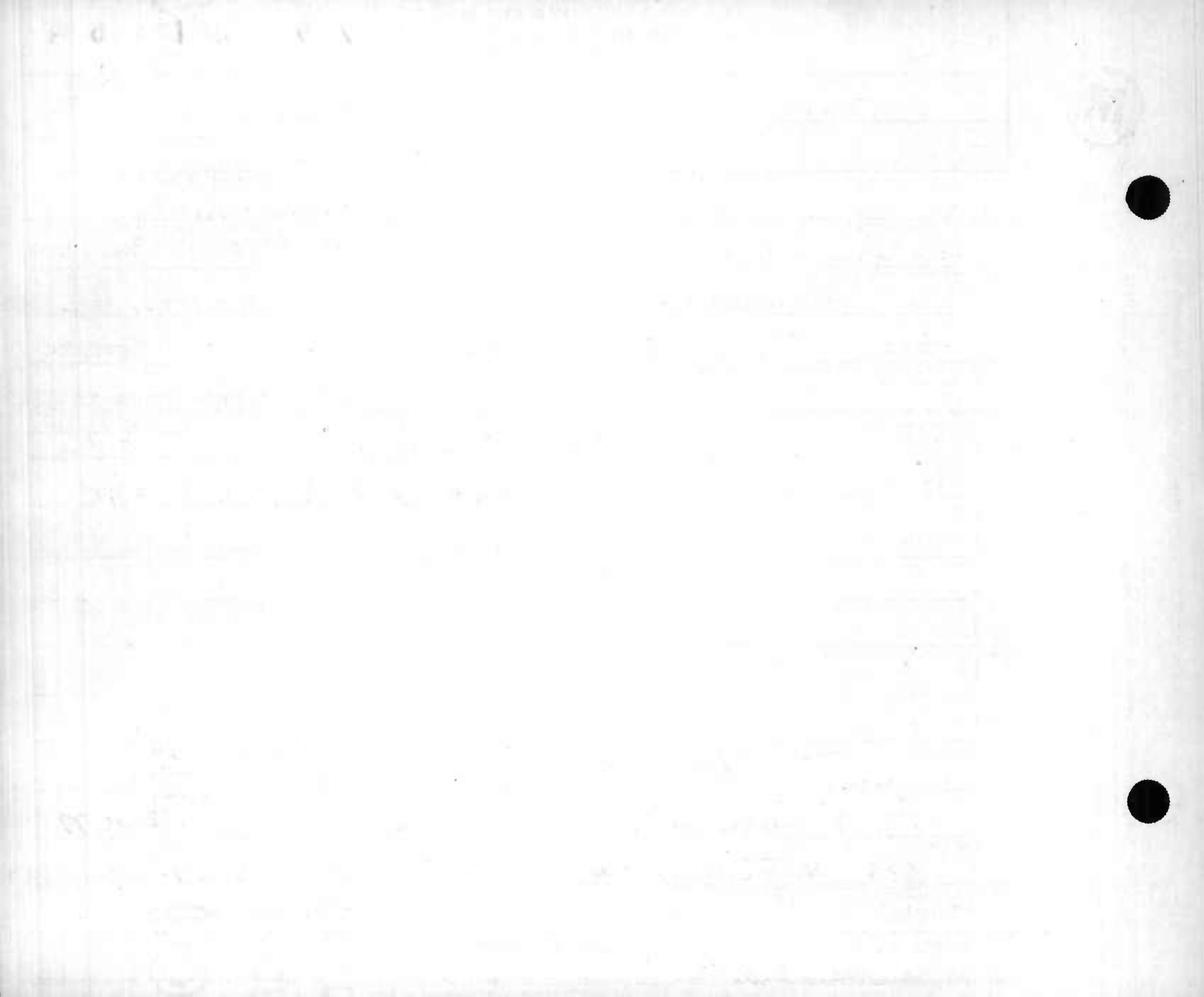
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0098-270-8771

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 79 31164						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Martha D Aycock						December 2 1979			2 48 AM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN	
Female	White	3 02 03		76 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	USA				Montgomery MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		Holy Cross Hospital			Housewife		own home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD			Montgomery		Sil Spring		2100 Dexter Ave., Apt. 201		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Howard T. Light			Ella May Demmitt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			none		212-74-1439 Thomas C. Aycock-husband-(same as 13e)				
11. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c):									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration Pneumonia									8 days
5303 DUE TO, OR AS A CONSEQUENCE OF Esophageal Stricture									2 yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 30 Nov 19 79, to 2 Dec 19 79, that (I) (we) lost saw the deceased alive on 1 Dec 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (we) (did not) view the body after death.			22b. SIGNATURE			DEGREE		22c. DATE SIGNED	
22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
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22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. SIGNATURE			22b. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22b. SIGNATURE									

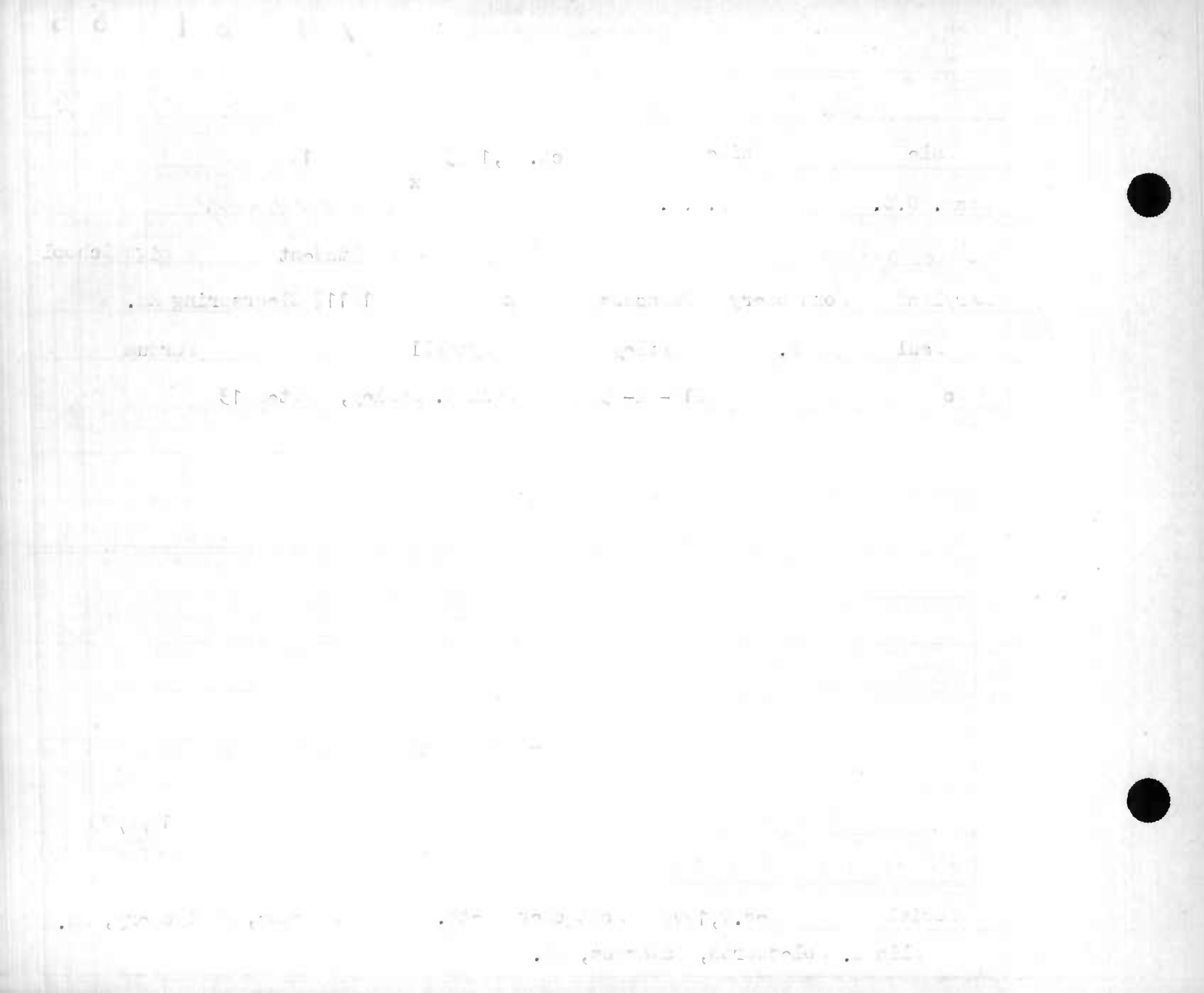


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.				7 9 3 1 1 6 5					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
David		Lee		Bailey				12-4-79		5:18 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		Oct. 8, 1963		16 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Wash. D.C.		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				Student		High School			
13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Montgomery		Damascus		YES		10112 Clearspring Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Paul D. Bailey		Lyndall Purdum									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		219-92-9396		Paul D. Bailey,		Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) IRREVERSIBLE SHOCK.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
486- DUE TO, OR AS A CONSEQUENCE OF SEVERE HYPOTIA											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF RAPIDLY PROGRESSIVE PNEUMONIA											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/3/79 AM, 1979, to 12/4 5:18 AM, 1979, that (I) (we) last saw the deceased alive on 12/4 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
Romulo A. Camargo		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12/4/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
ROMULO A. CAMARGO, M.D.		3800 BELPRE Rd. SILVER SPRING MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Dec. 7, 1979		Montgomery Meth.		Damascus, Montgomery, Md.					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth, Damascus, Md.				DEC 6 1979				[Signature]			



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 3 1 1 6 6	
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH	
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) Alma P. Ball					2a. DATE OF DEATH MONTH DAY YEAR 12 2 79			2b. HOUR 11:50 P.M.			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 7 30 1893		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Md.					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Charles Petty					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eulalie L. Hicks						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 214-48-8143		17 INFORMANT ADDRESS 8703 Irvington Ave. Mildred Groves Bethesda, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Intestinal obstruction</u>											
19a. DATE OF OPERATION 11/29/79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 12/2/79 to present 1979, that (1) (we) lost saw the deceased alive on 12/2/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.											
22b. SIGNATURE J.B. Umbau MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umbau MD						22e. ADDRESS 8805 Conn. Ave. Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Herndon Virginia			
24 FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.						25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Anna Louisa Ballenger			2a. DATE OF DEATH MONTH DAY YEAR December 19, 1979			2b. HOUR 4⁴² PM					
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY) Washington Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b KIND OF BUSINESS OR INDUSTRY Retail					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Montgomery		13c CITY OR TOWN Silv. Spr.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1023 N. Noyes Drive		
14 FATHER'S NAME FIRST MIDDLE LAST Charles E. Kamm			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise UKWN Knatz			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 579-28-3142A	
17 INFORMANT ADDRESS Carolina Shores, North Carolina.											
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF (c) 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost sight of the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.											
22b. SIGNATURE Thomas A. Bensinger			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/20/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. BENNINGER			22e. ADDRESS 831 Univ. Blvd E. Sil Spg Md 20903								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/22/79		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Balt. Balt. City Md.			
24. FUNERAL DIRECTOR Takoma Funeral Home Inc.			25a. DATE REC'D. BY REGISTRAR DEC 21 1979			25b. REGISTRAR'S SIGNATURE [Signature]					
254 Carroll St. Wash. D.C.											

254 Carroll St. Wash. D.C.
Tolson Funeral Home Inc.

Burial 12/22/79 London Park Cemetery Baltimore, Md.

James A. Patterson, Jr. E 2124 W 28th St
12/22/79



579-28-3121 Carl W. Ballenger North Carolina
579-28-3121 Carl W. Ballenger North Carolina

NO 579-28-3121 Carl W. Ballenger North Carolina
Charles E. Famm Louise

1023 N. Hayes Drive
Montgomery Blvd. Box X

Washington Hospital
Salmonson Retail

U.S.A. Montgomery

White Oct. 11, 1973 88



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 3 1 1 6 8				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alberta Mae Balster</i>					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>12 14 1979 7⁰⁵ PM</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 3 1897</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Bethesda Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fernwood House</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
USUAL RESIDENCE (# NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>D.C.</i> 13b. COUNTY <input checked="" type="checkbox"/> 13c. CITY OR TOWN <i>Washington</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3504 Idaho Ave N.W.</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>LONAS CRAVEN</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MATHILDA BLAKE</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>578-34-3373</i>		17. INFORMANT ADDRESS <i>Joan B. Kramm, Dtr., Same as item 13.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized Arterio sclerosis</i> <i>436-</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Some years</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Cerebrovascular Accident, Sept 1979</i>									
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> 19 <i>79</i> , to <i>Dec 14</i> 19 <i>79</i> , that (we) lost the deceased alive on <i>12/14</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <i>James W. Egan M.D.</i>					DEGREE <i>M.D.</i>			22c. DATE SIGNED <i>12/14/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES W. EGAN</i>					22e. ADDRESS <i>5413 Cedar Ln. - Bethesda, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/17/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR <i>Joseph M. Gawler's Sons Inc.</i>					25a. DATE REC'D. BY REGISTRAR <i>DEC 19 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>		
25c. ADDRESS <i>5130 Wisconsin Ave., N.W. Wash., D.C.</i>									



X

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9		3 1 1 6 9	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Pedro D. Baquial				2a. DATE OF DEATH MONTH 12 DAY 12 YEAR 79				2b. HOUR 3:00 PM					
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH 4 DAY 29 YEAR 11		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7. IF UNDER 24 HRS HOURS 0 MIN 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILLIPINES		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY NAVY YARD					
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11600 GAIL STREET			
14. FATHER'S NAME FIRST BAQUIAL MIDDLE BAQUIAL LAST BAQUIAL				15. MOTHER'S MAIDEN NAME FIRST VICTORIA MIDDLE DIGAL LAST DIGAL									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT PABILCIA BAQUIAL		ADDRESS SAME AS 13		WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic heart disease 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with congestive heart failure (c) heart failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from 11/19/79 to 12/3/79 , that (I) (we) last saw the deceased on 12/3/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
23a. SIGNATURE BARRY N. ROSENBAUM				DEGREE MD				23c. DATE SIGNED 12/3/79		23b. MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
24a. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY N. ROSENBAUM				24b. ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD 20795									
25a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				25b. DATE 12/6/79		25c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		25d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MONTGOMERY MARYLAND					
26. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						27a. DATE REC'D. BY REGISTRAR DEC 6 1979		27b. REGISTRAR'S SIGNATURE [Signature]					

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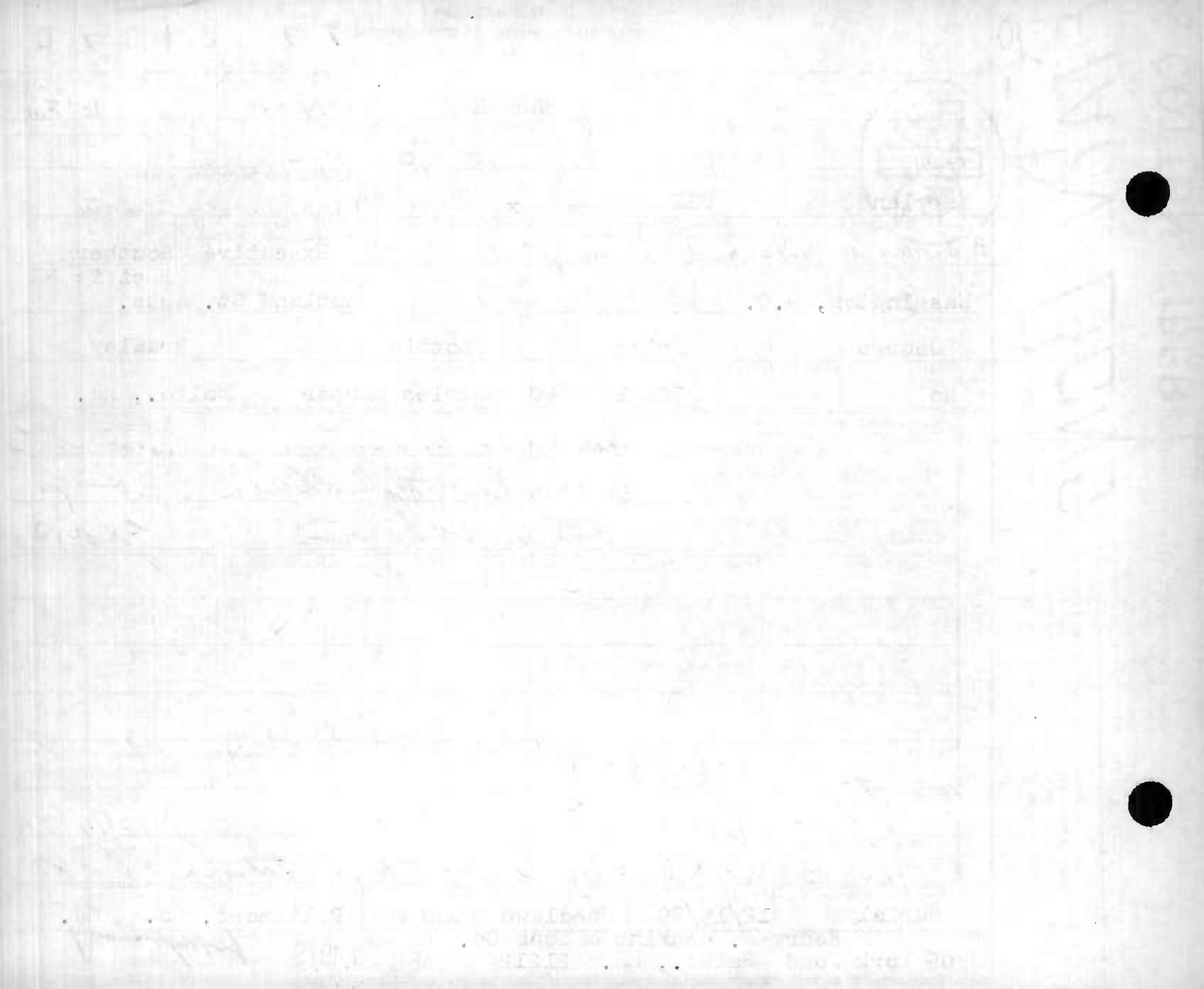
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			79 3 11 70 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Amy Price BARBER			2a. DATE OF DEATH MONTH DAY YEAR 12-14-79				2b. HOUR 6:15 AM		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9 18 98		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda Maryland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY Southern	
13a. STATE Washington, D.C.		13b. COUNTY 13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Pacific RR Rutland Ct. Apts.			
14. FATHER'S NAME FIRST MIDDLE LAST George Price			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Bradley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 700 16 9560		17. INFORMANT Charles Harper			ADDRESS Balto., Md.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arrhythmic Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED W/HEM AT WORK <input type="checkbox"/> HOT W/HEM AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1979</u> to <u>12/14/79</u> , that (I) (we) last saw the deceased alive on <u>12/13/79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE Thos G. Ward MD DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/79	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD				23b. ADDRESS 6116 Robinson, Bethesda, Md. 3x					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Co Md.			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR DEC 17 1979					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

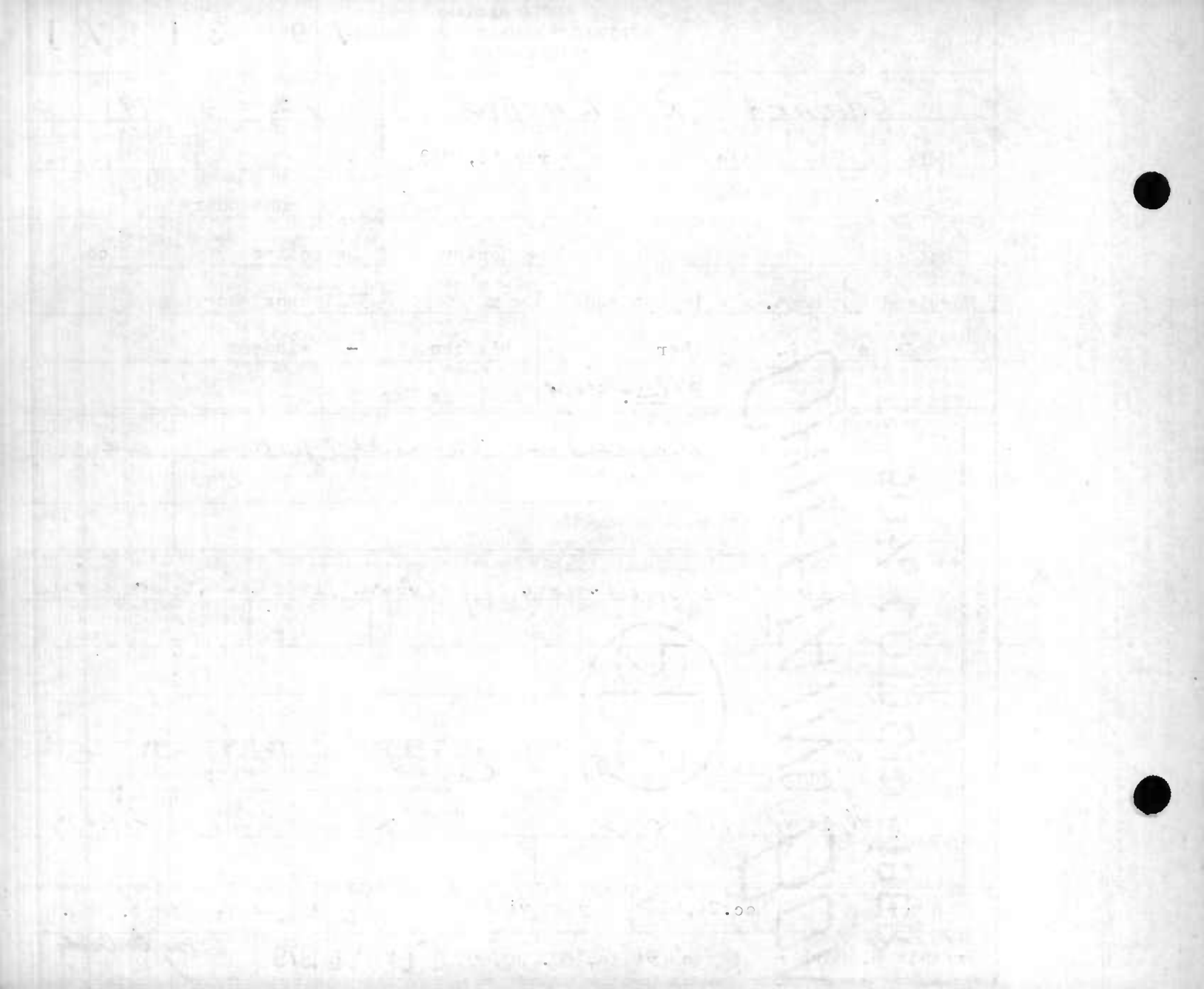
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 3 1 1 7 1				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Edward R. Barber					12-19-79				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Male		white		March 18, 1913		66		1 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		USA				Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Bethesda Health Care Center				Detective		Police	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland			Mont.		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME (FIRST MIDDLE LAST)					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)				
Jesse L. Barber					Blanche - Windsor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
yes WWII					577-46-50604		Florence Strother		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>emphysema, bronchial infection</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>496 -</u> (c) <u>days</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>atherosclerosis, urinary infection, cerebral thrombosis</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>August 19 77</u> to <u>12/19 77</u> , that (2) (we) lost saw the deceased alive on <u>12/15 77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
<u>[Signature]</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			12/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Dec. 21, 1979		Laytonsville		Laytonsville Mont. Md.		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRY	
Francis H. Barber Laytonsville, Md. 20760						DEC 20 1979		<u>[Signature]</u>	

4401 BP



CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Albert D. Battista			2a. DATE OF DEATH MONTH DAY YEAR Dec 17 1979			2b. HOUR 1:50 P.M.				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2 1887		6 AGE (IN YEARS LAST BIRTHDAY) 92		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stone Contractor		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7405 River Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Benedetto			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Septimia Yaselli			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 578-50-3623			17. INFORMANT Albert J. Battista, Son.			ADDRESS Wash., D.C. 4334 Reno Rd., N.W.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 20 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12-17 , 19 78 , to 12-17 , 19 79 , that (I) (we) last saw the deceased alive on 12-17 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Stephen W. DeJeter, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-17-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN W. DEJETER, M.D.			22e. ADDRESS 6719 WILSON LANE, BETHESDA, MD. 20834							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/20/1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Lawler's Sons Inc. 5130 Wisc. Ave/ N.W. Wash., D.C.			25a. DATE REC'D. BY REGISTRAR DEC 20 1979			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO : DIRECTOR, FBI (100-374301)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED]

RE: NEW YORK TELETYPE TO BUREAU, 1/10/50.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE MATTER:

ON 1/10/50, [REDACTED] ADVISED THAT [REDACTED]

[REDACTED] STATED THAT [REDACTED]

[REDACTED] ADVISED THAT [REDACTED]

[REDACTED] STATED THAT [REDACTED]

[REDACTED] ADVISED THAT [REDACTED]

[REDACTED] STATED THAT [REDACTED]

[REDACTED] ADVISED THAT [REDACTED]

[REDACTED] STATED THAT [REDACTED]

[REDACTED] ADVISED THAT [REDACTED]

[REDACTED] STATED THAT [REDACTED]

[REDACTED] ADVISED THAT [REDACTED]

[REDACTED] STATED THAT [REDACTED]

[REDACTED] ADVISED THAT [REDACTED]

[REDACTED] STATED THAT [REDACTED]

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 1 7 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John P. BAUR			2a. DATE OF DEATH MONTH DAY YEAR 12-10-79			2b. HOUR 8:17 P M			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR NOV 19, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. # UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SYSTEMS ANALYST		12b. KIND OF BUSINESS OR INDUSTRY TREAS. DEPT.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST GEORGE J. BAUR		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH HIPKINS		13e. STREET ADDRESS 12500 GAIWAY DRIVE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578-34-3419		17 INFORMANT JOAN S. BAUR		ADDRESS SAME AS 13 WIFE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4289 IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/10, 1979, to 12/10, 1979, that (I) (we) last saw the deceased alive on 12/10, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Francis J. Collins				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. FRANCIS J. COLLINS				22e. ADDRESS 8218 WILCOX AVE BETHESDA					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/13/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24 FUNERAL DIRECTOR'S NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE [Signature]			
500 UNIV. BLVD., W., SILVER SPRING, MARYLAND									

MEDICAL CERTIFICATION EXAMINER

CLEARED BY REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 in retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Multiple Pulmonary Emboli

Cardiac respiratory failure

Journal of Management Education

95/21/31

Gate of Heaven

FRANCIS J. COLLINS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 1 7 4	
1. DECEASED NAME (TYPE OR PRINT) Edith P. Becker						2a. DATE OF DEATH MONTH DAY YEAR 12/17/79		2b. HOUR 7:30 PM			
3. SEX female		4. RACE W		5. DATE OF BIRTH June 4, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 71 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retiree		12b. KIND OF BUSINESS OR INDUSTRY Homemaker			
13a. STATE Maryland						13b. CITY OR TOWN Rockville		13c. STREET ADDRESS 257 Congressional Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Aaron Pearlman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Weiss			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A					
16b. SOCIAL SECURITY NO 335-30-3760			17. INFORMANT Stephen Becker, 20 Eton Overlook, Rockville, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 3-5 days years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>12/17</u> 19 <u>79</u> , to <u>12/17</u> 19 <u>79</u> , that (1) (we) lost <u>saw</u> the deceased alive on <u>12/17</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Samuel D. Goldberg MD</u>						22c. DATE SIGNED 12-17-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel D. Goldberg MD						22e. ADDRESS 1125 Rockville Pike Rockville, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-19-79		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gdn.		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.						25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 21 1979					

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

3 1 1 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>BERNARD J. BECKMANN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12/28/79</i>		2b. HOUR <i>12:35 AM</i>						
3. SEX <i>Male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sep. 11 1923</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>56</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery Co.</i> MD.					
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUBURBAN HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>U.S. Gov't.</i>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4801 Oxbow Road</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Bernard J. Beckmann</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Inez Finney</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII</i>		17. INFORMANT <i>wife</i>			ADDRESS <i>Angelina C. Beckmann same as 13e</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> <i>3481</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio Brain Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>COPD</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the hospital) attended the deceased from <i>12-15</i> , 19 <i>79</i> , to <i>12-28</i> , 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>12-27</i> , 19 <i>79</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Carol L. Bender</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12-28-79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Carol L. Bender</i>			22e. ADDRESS <i>11125 Rockville Pike Rockville, Maryland</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Dec. 31, 1979</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>			ADDRESS <i>500 University Blvd., West Silver Spring, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 2 1980</i>			25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>		

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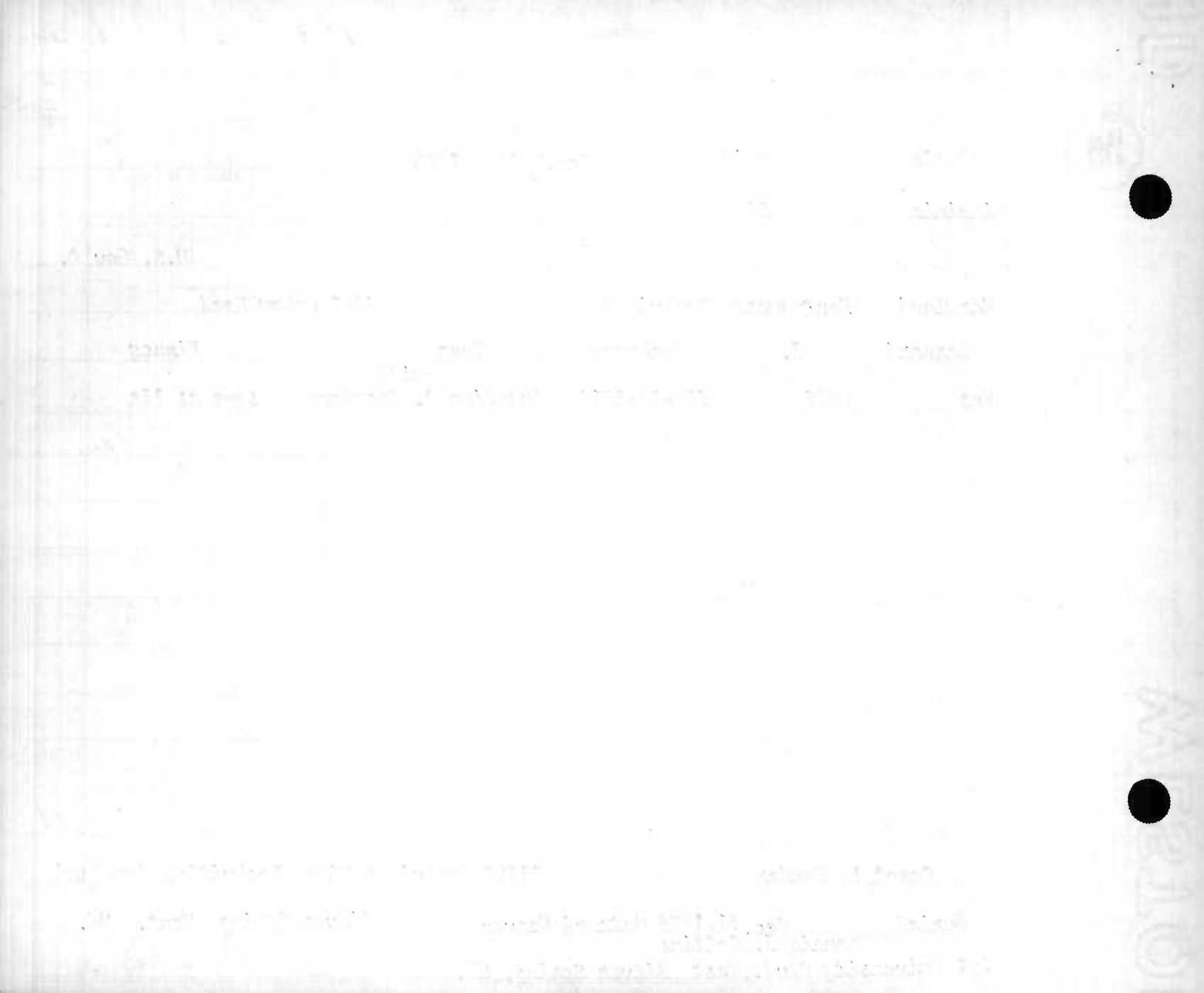
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



1201





FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 31176
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Glady's C Belt			2a. DATE OF DEATH MONTH DAY YEAR 12-30-79			2b. HOUR 8:20 M	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8-21-07		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Silver Spring				13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 2510 Kimberly Street,	
14. FATHER'S NAME FIRST MIDDLE LAST Coleman R. Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215-36-4884		17. INFORMANT (son) ADDRESS Walter E. Belt, Jr. Silver Spring, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

PNEUMONIA

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 MO

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Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **PARKINSONS DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (myself) attended the deceased from **30 DEC 1979** to **30 DEC 1979**, that (I) (we) last saw the deceased alive on **30 DEC 1979**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.

22b. SIGNATURE Walter E. Gooch MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 31 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25. DATE REC'D. BY REGISTRAR JAN 4 1980		25b. REGISTRAR'S SIGNATURE Walter E. Gooch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Dr. Ball, M.E.O. Notified and Aptoved

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR		7 9 3 1 1 7 7				REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST Beatrice		MIDDLE H.		LAST Bemis		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		Dec. 31 1894		84		MONTHS		DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH									
Mass.		S.A.				Montgomery						MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda		Suburban Hospital		Homemaker		Home									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13b. CITY OR TOWN		13c. STREET ADDRESS									
Maryland		Montgomery		Bethesda		5404 Burling Road									
14 FATHER'S NAME		15 MOTHER'S MAIDE-4 NAME													
D.		Augustus Hepworth		Anna		I.		Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS									
No		578-24-9159		Mrs Garwood Chamberlin, Daughter.		Same as ite									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE 10-15 years DUE TO, OR AS A CONSEQUENCE OF (c) GENERALIZED ARTERIOSCLEROSIS 20 years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		2 hours			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from June 1979, to November 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
										E. Morell					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
EVA M. MORELL										7936 OLD GEORGETOWN RD, BETH.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial		12/6/1979		Arlington National Cemetery		Arlington, Virginia.									
24 FUNERAL DIRECTOR Joseph Gawler's Sons Inc. NAME ADDRESS 5130 Wisc. Ave., N.W. Washington, D.C.						25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
						DEC 7 1979									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

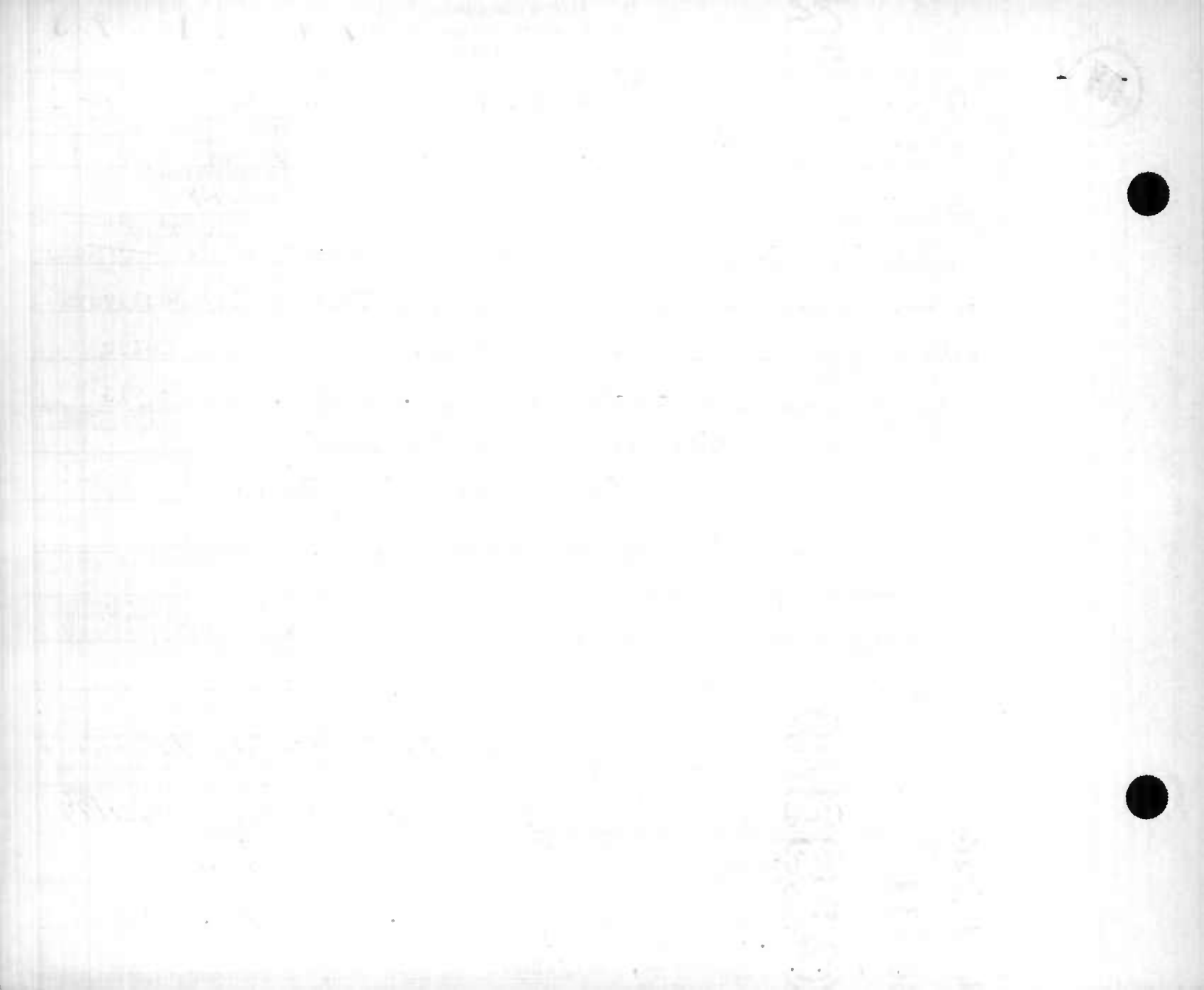
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				79 31178			
1 - FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FLORA S BETANCOURT				2a DATE OF DEATH MONTH DAY YEAR December 31 79		2b HOUR 15 A.M.	
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec 24 1889		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CUBA		7b CITIZEN OF WHAT COUNTRY? CUBA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5728 Bradley Boulevard		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland				13b COUNTY Montgomery		13c CITY OR TOWN Bethesda	
14 FATHER'S NAME FIRST MIDDLE LAST Luis Sanchez				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela Soler			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 112-20-0423		12 INFORMANT ADDRESS Jeannie B. Redmond, Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC HEART FAILURE</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>MAY 13 1979</u> to <u>Dec 31 1979</u> , that (I) (we) lost saw the deceased alive on <u>Dec 29 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>M. D. Cascard</u>				DEGREE M.D.		22c DATE SIGNED 12/31/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MIGUEL R CASCARDO				22e ADDRESS 12400 BOBINK CT POTOMAC, Md 20854			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 1/1/80		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland				25a DATE REC'D. BY REGISTRAR JAN 4 1980		25b REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

5903



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP
DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 1 7 9

1. FOR
STATE
REGISTRAR

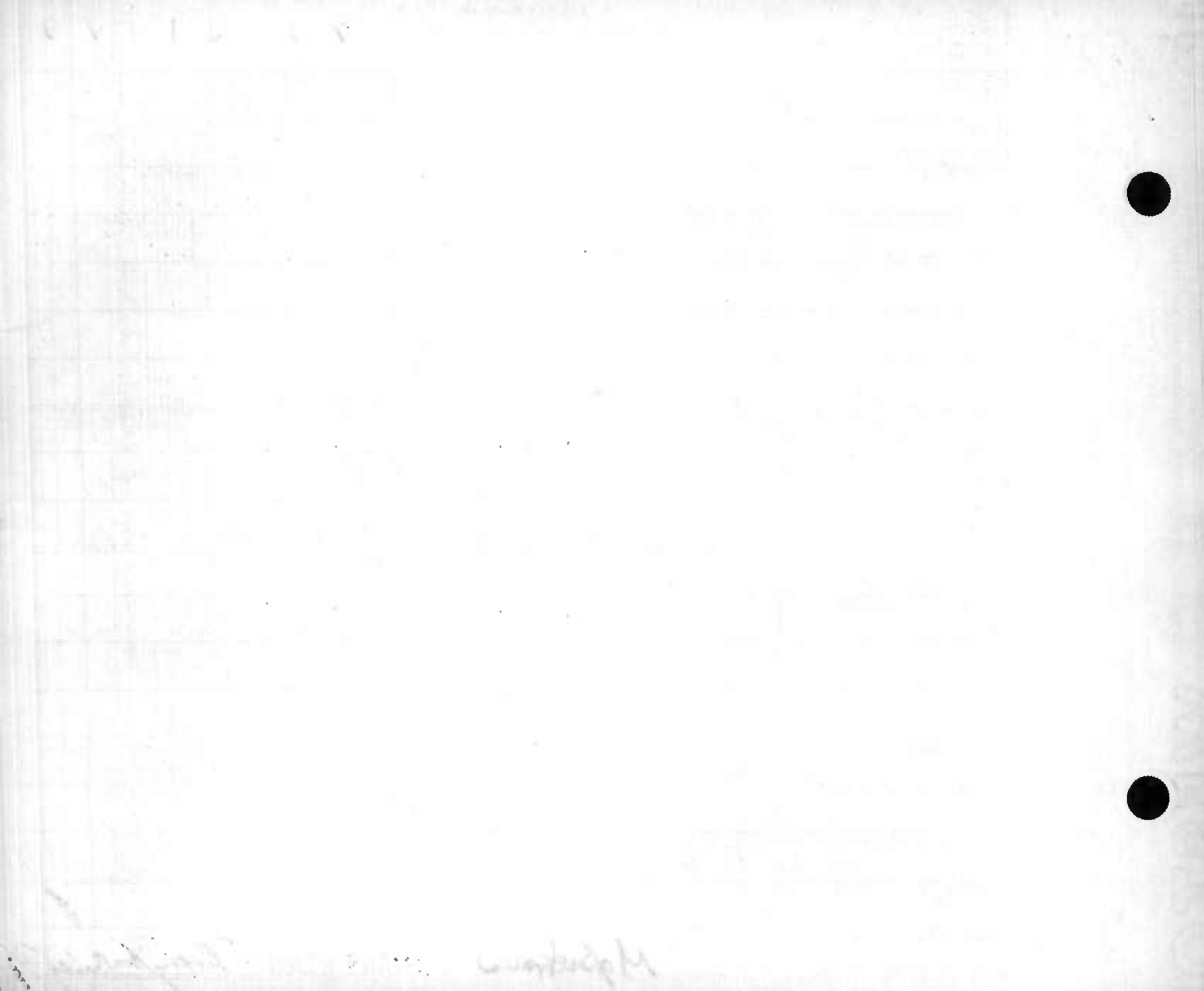
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ESTHER		FIRST BLACK		LAST		2a. DATE OF DEATH MONTH DAY YEAR 12 11 79		2b. HOUR 8:48 A.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 19 07		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden		7b. CITIZEN OF WHAT COUNTRY? Sweden		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleswoman		12b. KIND OF BUSINESS OR INDUSTRY religious material	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Tak. Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 521-46-8123				17. INFORMANT (daughter) Viveca Black Branson-Arlington, Va.		ADDRESS 1021 Arl. Blvd.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest. 410- DUE TO, OR AS A CONSEQUENCE OF (b) Death anterior MI DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory insufficiency, hypotension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr 8 hrs. 2 days.	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): COPD, Diabetes Mellitus			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/9 19 79 , to 12/11 19 79 , that (I) (we) last saw the deceased alive on 12/10 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Norton Elson MD		DEGREE CONSULTING ATTENDING <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 12/11/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norton Elson	
22e. ADDRESS 6525 Belcrest Rd Hyattsville Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-17-79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Georges Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc 8434 Ga. Ave., S.S. Md.				25a. DATE REC'D. BY REGISTRAR JAN 16 1980		25b. REGISTRAR'S SIGNATURE Henry Bailey	





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert L. BLANDING			2a. DATE OF DEATH MONTH DAY YEAR December 16 1979			2b. HOUR 7:45A M										
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7 1927		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD										
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy Captain		12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia			13b. COUNTY Alexandria		13c. CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8334 Blowing Rock Road							
14. FATHER'S NAME FIRST MIDDLE LAST William Blanding			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cleora Lightbourn			16. ADDRESS Mrs. Marilyn A. Blanding See item 13										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1952-1979		16c. 267 28 3981		17. INFORMANT Mrs. Marilyn A. Blanding See item 13									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) ARDS - diffuse interstitial pneumonia Fibrrosis 43 days DUE TO, OR AS A CONSEQUENCE OF (c) Stage Cancer of the Lung 2 mos.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION 29 Oct 1979			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of the Lung				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from Oct. 22, 1979, to Dec. 16, 1979, that (I) (we) lost saw the deceased alive on Dec. 16, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													22b. SIGNATURE Michael Swank M.D.		22c. DATE SIGNED Dec. 18 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Swank			22e. ADDRESS National Naval Medical Center, Bethesda, Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/21/79		23c. NAME OF CEMETERY OR CREMATORY Lake Wales Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Lake Wales Polk Florida								
24. FUNERAL DIRECTOR NAME W. W. Chambers Co.					ADDRESS Silver Spring, Md.			DATE OF REGISTRATION DEC 20 1979								

STATE OF NEW YORK
IN SENATE
JANUARY 15, 1901



15/15

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Norman S. Blankenship			2a. DATE OF DEATH MONTH DAY YEAR Dec. 3, 1979			2b. HOUR A MIN 2:45				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 20, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Master Mech.		12b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10655 Weymouth St.	
14. FATHER'S NAME FIRST MIDDLE LAST Wilbur L. Blankenship			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Engel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-62-6989		17. INFORMANT Betty A. Blankenship		ADDRESS Same as 13				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 4912 DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema and chronic bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one week years.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) cerebrovascular insufficiency										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (a) (this hospital) attended the deceased from FEB 6 , 19 79 , to Dec 3 , 19 79 , that (b) (we) lost saw the deceased person above, (c) (we) (did) (did not) view the body after death. 11/28 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE Martin C. Sharpe M.D.				DEGREE MD.				22c. DATE SIGNED 12/3/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARPE M.D.				22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD - 20795						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 5, 1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Norman S. Blum/Barrie Dec. 3, 1979

1915 Caucasian March 20, 1978

USA Montgomery

Anderson Randolph Hills Nursing Home, Master Tech. Level 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 31182

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George T. Bleakley			2a. DATE OF DEATH MONTH DAY YEAR 12 24 79			2b. HOUR 9 ²⁰ AM	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR May 31, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12829 Baker Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Bleakley				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS 12829 Baker Dr. Margaret R. Bleakley, Silver Spring, Md. 20904			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE 1552 DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA of the LIVER DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS KNOWN FOR 9 DAYS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): HEPATITIS "A"							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/16 19 79 to 12/24 19 79, that (I) (we) last saw the deceased alive on 12/22 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arnold G. Levy M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD G. LEVY, M.D.				22e. ADDRESS 1106 SPRING ST., SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/24/79		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				25a. DATE REC'D. BY REGISTRAR JAN 2 1980			
11800 New Hampshire Ave., Silver Spring, Md. 20904				25b. REGISTRAR'S SIGNATURE [Signature]			

CHARTERED ACCOUNTANTS

DATE: 11/11/2011 11:11 AM

2003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 3 1 1 8 3				REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) Nelson F. Blechman					2a. DATE OF DEATH MONTH DAY YEAR 12/24/79			2b. HOUR 4:12p M		
3 SEX male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 3 23 05		6 AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4701 Willard Avenue			
14 FATHER'S NAME FIRST MIDDLE LAST Gus Blechman					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gerber					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-44-9454		17 INFORMANT ADDRESS Lucille Blechman; 4701 Willard Ave., Ch Ch, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Recent massive myocardial infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/12 19 79 to present 19 79 , that (I) (we) lost saw the deceased alive on 12/12 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lester I. Marion MD			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/25/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lester I. MARION MD					22e. ADDRESS 106 Irving St, NW, Washington 20010					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24 FUNERAL DIRECTOR NAME DAN ZANSKY GOLDERS					ADDRESS 430 Rockville		25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

1935-1-18

1935-1-18

Notary Public

male

3 02 05

Montgomery County

Suburban Hospital

Bethesda

1935-1-18

Notary Public

Montgomery County

Suburban Hospital

Bethesda

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

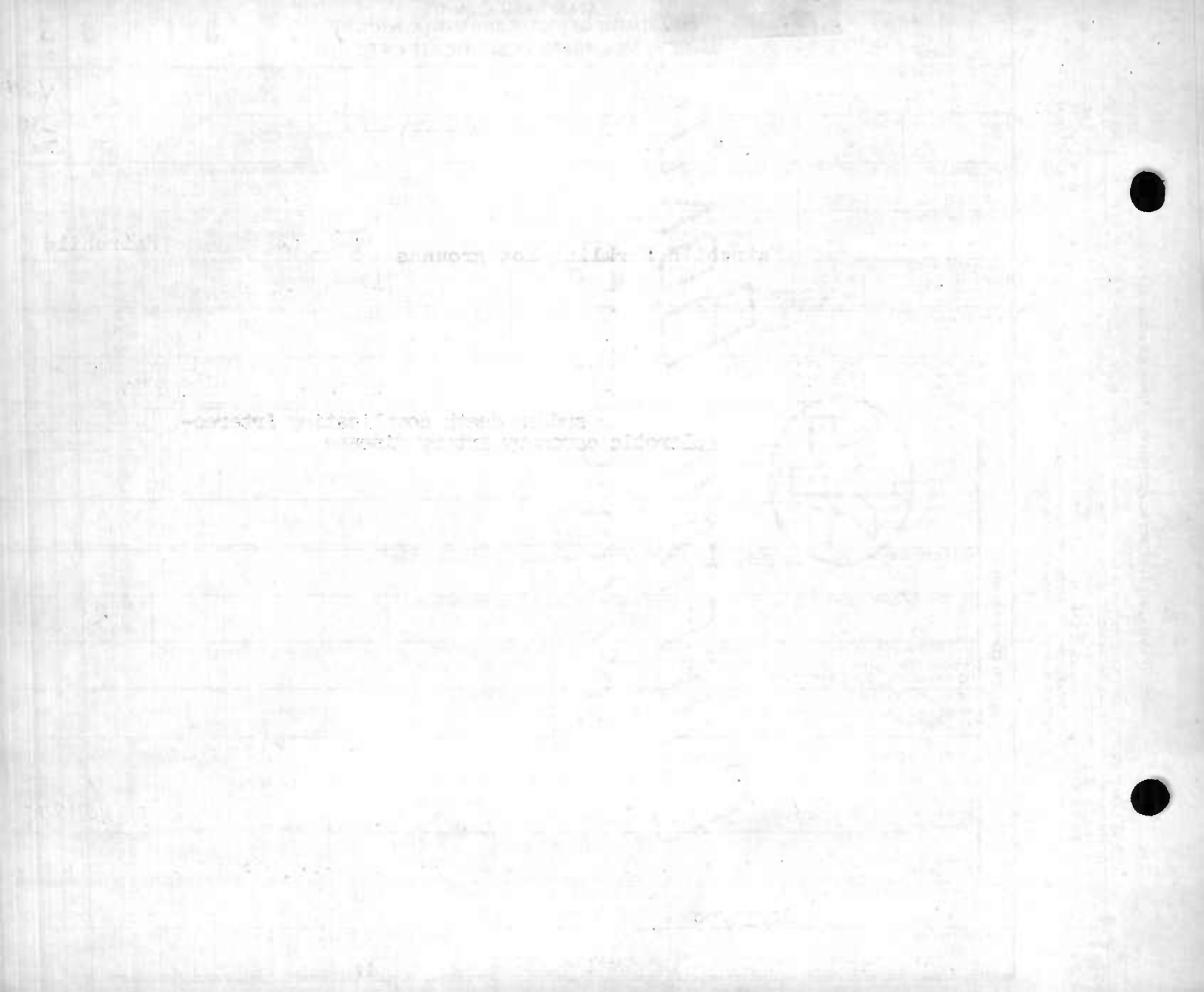
9 31184

FOR 1- STATE REGISTRAR		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		GLADYS G. BOLGER		DATE ESTIMATED		12-19 1979		11 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH		MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.	4292		Coronary Insufficiency Acute.		Cardio Vascular Disease.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION					
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner									
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME		ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FURNISH COPIES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR Items 2a., 2c. Film# 0530										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 3 1 1 8 5																																																											
1- STATE REGISTRAR 1-24-80 al										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. Noon																																																											
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH										2b. HOUR																																																	
William										Burton										Bond										Dec. 9 1979										Noon																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.										7c. DATE PRONOUNCED DEAD										7d. HOUR									
Male										Caucasian										Apr 6 1920										59 YRS.																														December 9 1979										5:50 P.M.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										NEVER MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH																																							
Massachusetts										U.S.A.										WIDOWED										DIVORCED										Montgomery										MD.																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Germantown										Fairchild Parkling lot grounds										Photo Engineer										Fairchild																																																	
13a. STATE										13b. CITY OR TOWN										13c. INSIDE CITY LIMITS?										13d. STREET ADDRESS																																																	
Maryland										Montgomery										Gathersburg										YES X NO										210 Oakton Road																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
Thomas										Alex										Bond										Florence										Winward																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																																																	
Yes										22yrs										016-16-7920										Margaret C. Bond										210 Oakton RD,										Gathersburg Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF																																																											
4140										sudden death complicating Artereo-										sclerotic coronary artery disease																																																											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)																																																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																											
																				YES X NO																																																											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																											
										HOUR A.M. MONTH DAY YEAR																																																																					
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																																																											
																				STREET CITY OR TOWN COUNTY STATE																																																											
22a. I certify that I took charge of the remains described above, held on										Autopsy										Inspection										Inquiry										and in my opinion																																							
death resulted from:										Natural causes										Accident										Suicide										Homicide										Undetermined manner																													
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																											
John G. Ball										M.D. DePuy										Dec. 10, 1979																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																					
John G. Ball, M. D.										7936 Old Georgetown Rd. Bethesda Md.																																																																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																																																	
Burial										12/13/79										Arlington Natl Cem										Arlington Arlington Va																																																	
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
NAME ADDRESS										DEC 13 1979																																																																					
Tyson Wheeler Funeral Home										Rockville Md.																																																																					



Cleared & M.E.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 31186

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Beulah P. Bowar			2a. DATE OF DEATH MONTH Dec DAY 15 YEAR 79			2b. HOUR 10³⁰ PM					
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH Jan. DAY 15 YEAR 1924		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13816 Marianna Drive		
14. FATHER'S NAME FIRST Peter MIDDLE LAST Gulbranson			15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE LAST Otterness								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 470-22-6181			17. INFORMANT husband			ADDRESS same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 431- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 15, 1979 to Dec. 15, 1979 , that (I) (we) lost saw the deceased alive on Dec. 15, 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Baltazar E. Perez MD						DEGREE			22c. DATE SIGNED Dec. 15/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BALTAZAR E. PEREZ						22e. ADDRESS 10620 Gensie Ave Silver Spring, Md - 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 19, 1979			23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR NAME Francis J. Collins						25a. DATE REC'D. BY REGISTRAR DEC 17 1979			25b. DATE REC'D. BY REGISTRAR DEC 17 1979		
500 University Blvd., West Silver Spring, Md.											

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

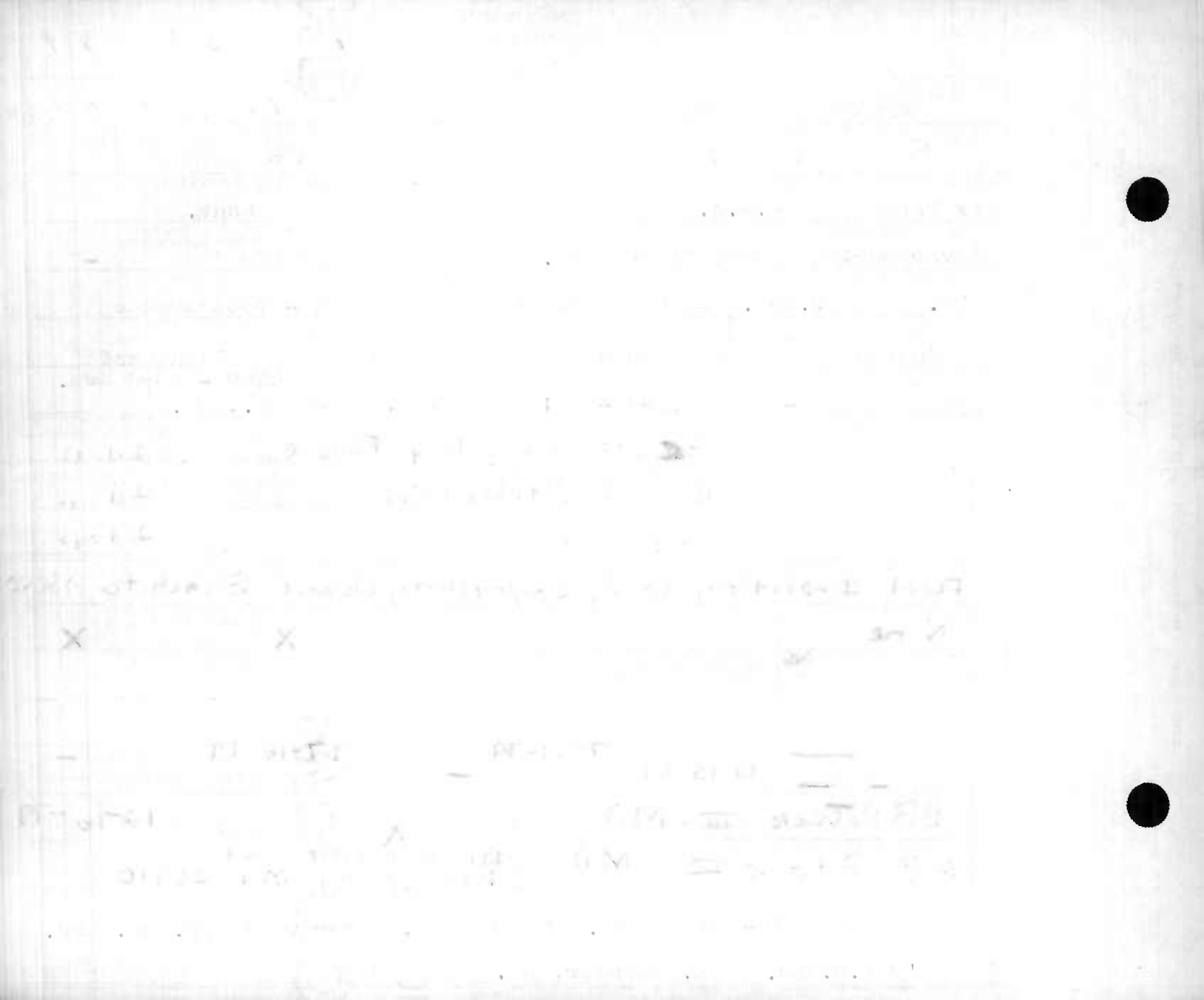
1350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 1 8 7	
FOR 1- STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) MARY			FIRST V			MIDDLE BOWES			LAST		
2a. DATE OF DEATH 12-16-79			MONTH			DAY			YEAR		
2b. HOUR 7:34 AM			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS OAYS			IF UNDER 24 HRS HOURS		
3 SEX F			4 RACE W			5 DATE OF BIRTH MONTH 4			YEAR 93		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Mont.		
10 CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY -		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Pr. Geo.			13c. INSIDE CITY LIMITS? Landover Hills			13d. STREET ADDRESS 4404 - 74th Avenue		
14 FATHER'S NAME FIRST Angelo			MIDDLE			LAST Monaco			15. MOTHER'S MAIDEN NAME FIRST Adelaide		
MIDDLE			LAST Garagucci								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-12-7971			17 INFORMANT Vincent A. Bowes Hy., Md.			ADDRESS 4209 - 73rd Ave.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
486 - DUE TO, OR AS A CONSEQUENCE OF (b) Decompensated Atelectasis										2 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia										2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Fecal Impaction, COPD, Emphysema, Chronic Bronchitis, ASCVD											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 7-17-79 , 19____, to 12-16-79 , 19____, that (1) was lost saw the deceased alive on 12-15-79 , 19____, and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (1) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE G.B. Patrick III MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-16-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.B. Patrick III MD			22e. ADDRESS 9321 Colesville Rd Silver Spring, Md 20910								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-20-79			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.		
24 FUNERAL DIRECTOR NAME Nalley's F.H. Inc.						ADDRESS Mt. Rainier, Md.			25a. DATE REC'D. BY REGISTRAR DEC 24 1979		
						25b. REGISTRAR'S SIGNATURE Forney McQuade					



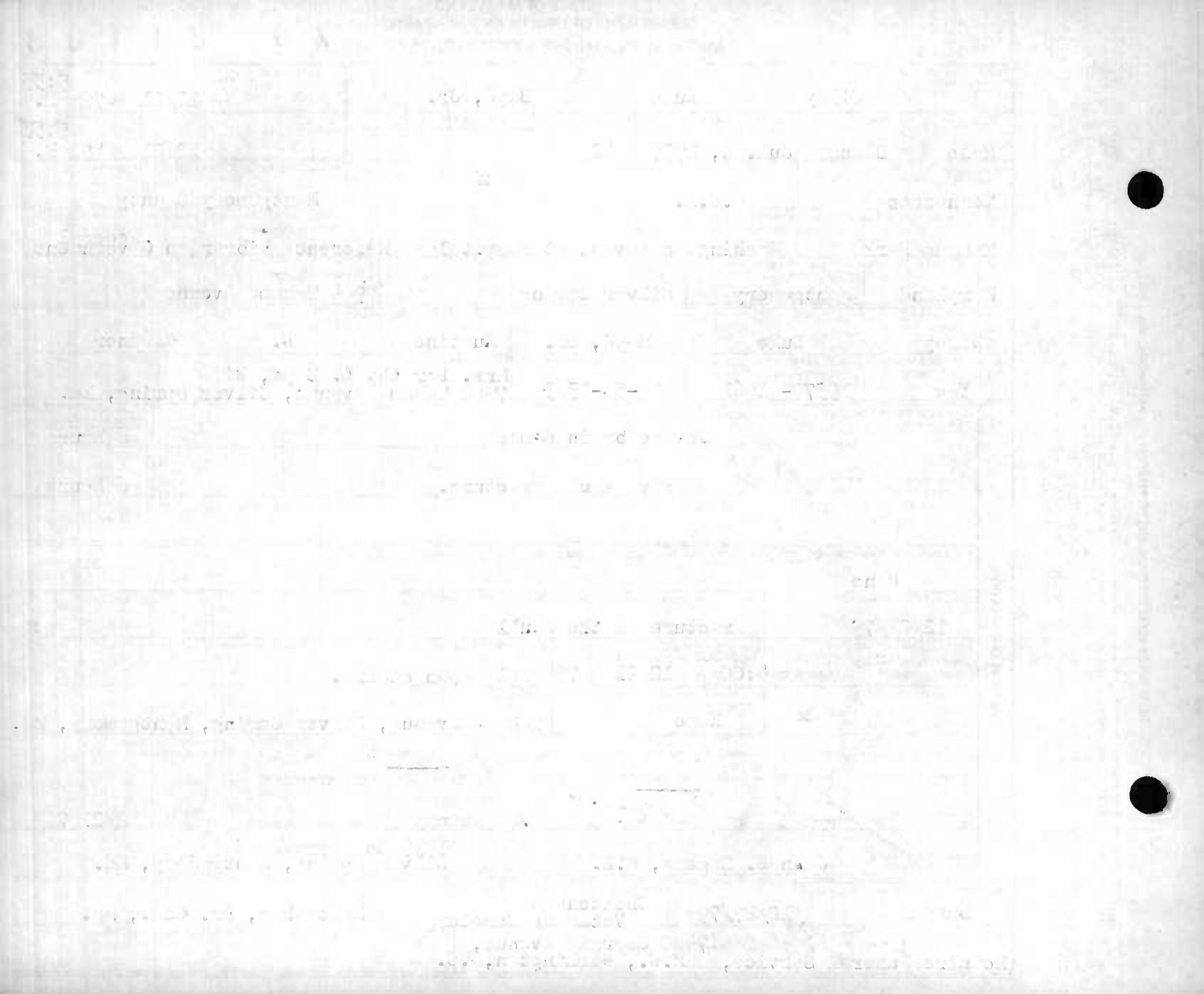
Rec'd orig. 1/2/80 kam FilmG540 2/4/80

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31188	
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME FIRST MIDDLE LAST Wiley Duke Boyd, Jr.										ESTIMATED <input checked="" type="checkbox"/> 12/21 1979 P. M.	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD	
Male		Black		Jul. 6, 1937		42 YRS.				12/21 1979 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Tennessee				U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Takoma Park				Washington Adventist Hospital				Reference Librarian Federal Government			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		7904 Takoma Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Wiley Duke Boyd, Sr.						Austine D. Gardner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes				1957 - 1961		Mrs. Dorothy L. Boyd, Wife 7904 Takoma Avenue, Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe brain damage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>massive skull fracture.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>6 hours</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
None											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
12/21/79				Fracture of the skull						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>1:00</u> P.M. MONTH DAY YEAR <u>12/21 1979</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Fell down stairs.</u>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Takoma Avenue, Silver Spring, Montgomery, Md.</u>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 12/21/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
John S. Rogers, M.D.				1919 Seminary Road Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				12/27/79		Cheltenham Veterans Cemetery				Cheltenham, Pr. Geo., Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John F. Bolder				7400 Georgia Avenue, N.W., Washington, D.C.				FEB 4 1980			

DHMH - 17
(VR A15 ME (1))
30M 7/73



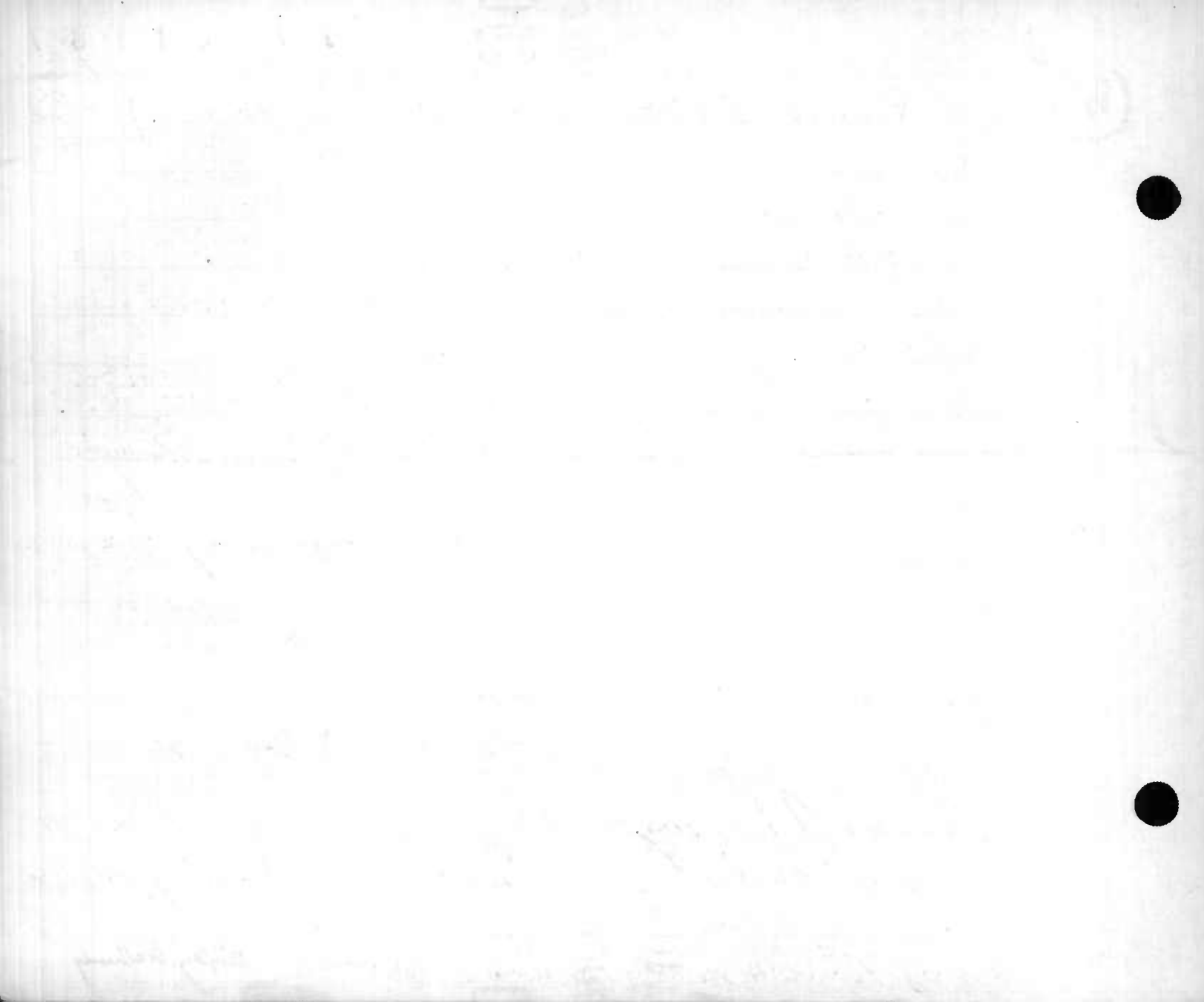
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 31189			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Phillip Wesley BREWER				2a. DATE OF DEATH MONTH 12 DAY 10 YEAR 79		2b. HOUR 5:20 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 5 DAY 08 YEAR 1935		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. STATE Maryland				13b. CITY OR TOWN Prin. Geo. Landover		13c. STREET ADDRESS 1724 Dutch Village Drive	
14. FATHER'S NAME FIRST Phillip MIDDLE Brewer LAST Brewer				15. MOTHER'S MAIDEN NAME FIRST Mildred MIDDLE Lee LAST Lee			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT Susie Brewer (wife) Oxon Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Small Cell Carcinoma of Lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 hours 3 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 15 Sept 19 79 to 10 Dec 19 79 , that (I) (we) last saw the deceased alive on 9 Dec 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas A. Benninger THE PHYSICIAN'S NAME (TYPE OR PRINT)				22c. DEGREE MD		22c. DATE SIGNED 10 Dec 79	
22b. ADDRESS 831 University Blvd E. S. Spg MD 20706							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland	
24. FUNERAL DIRECTOR NAME Latney's Funeral Home ADDRESS 3831 Ga Ave NW Wash. DC				25a. DATE REC'D BY REGISTRAR JAN 10 1980		25b. REGISTRAR'S SIGNATURE Latney's Funeral Home	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Nannie C. Briggs			2a. DATE OF DEATH Month December Day 21 Year 1979			2b. HOUR 1:10 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH March 27, 1895		6. AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10 Park Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12 Park Ave.	
14. FATHER'S NAME First Middle Last William - Roberts			15. MOTHER'S MAIDEN NAME First Middle Last Emma - Russman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 578-05-7068D		17. INFORMANT Mrs. Marjorie B. Bohrer		10 Park Ave., Gaithersburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 20 YEARS 20 YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) NEPHROSCLEROSIS WITH UREMIA - MOD. NUTRITION									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JAN 10, 1969 , to DEC 21, 1979 , that (I) (we) last saw the deceased alive on Dec. 20, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gordon S. Rosenberger, M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED December 21, 1979	
22d. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger, M.D.				22e. ADDRESS 310 W. Montgomery Ave., Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/24/79		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION (City or Town) (County) (State) Gaithersburg Montg. Maryland			
24. FUNERAL DIRECTOR Gartner-Sandison F. M.		ADDRESS 310 E. Diamond Ave. Gaithersburg, Md.		25a. REC'D BY REGISTRAR DATE DEC 26 1979		25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy			

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

Case No.	100-100000
Date	10/10/1960
Subject	JOHN EDGAR HOOVER
Re	Letter from [illegible] dated 10/10/60
From	[illegible]
To	[illegible]
Information	[illegible]
Comments	[illegible]
Disposition	[illegible]
Remarks	[illegible]
Signature	[illegible]
Special Agent in Charge	[illegible]
Director	[illegible]
Assistant Director	[illegible]
Administrative Services	[illegible]
Ident. Div.	[illegible]
Intell. Div.	[illegible]
Lab.	[illegible]
Legal Coun.	[illegible]
Plan. & Insp.	[illegible]
Rec. Mgmt.	[illegible]
Tech. Serv.	[illegible]
Training	[illegible]
Off. of Cong. & Public Affairs	[illegible]
Telephone Rm.	[illegible]
Director's Sec'y	[illegible]
Miss Gandy	[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 1 9 1			
FOR 1 - STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE V BROWN				2a DATE OF DEATH MONTH DAY YEAR 12/28/79		2b HOUR 6 ³⁰ P M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 6 18 95		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSP		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY HOME	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE MD.				13c CITY OR TOWN GANTHERBURG		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST GEORGE JACOB SCHAEFFER				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA ANN DOXEN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 215-48-0351		17 INFORMANT ADDRESS METH. HOME #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>79</u> , to <u>12/28</u> 19 <u>79</u> , that we (we) last saw the deceased alive on <u>12/28/79</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b SIGNATURE Marvin Watler		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/29/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN WATLER		22e ADDRESS 8218 Wincocksin Ave. Beth, Md.					
23a BURIAL, CREMATION, REMOVAL (TYPE)		23b DATE 12/31/79		23c NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		23d LOCATION CITY OR TOWN COUNTY STATE GANTHERBURG MONTGOMERY MD.	
24 FUNERAL DIRECTOR John M. Lupton		ADDRESS Chesapeake, Md.		25a DATE REC'D. BY REGISTRAR JAN 21 1980		25b REGISTRAR'S SIGNATURE Lupton	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the coroner, for page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the coroner after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 3 1 1 9 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eugene Golet Brown					2a. DATE OF DEATH MONTH DAY YEAR 12 02 79			2b. HOUR 11:40 PM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Jan. 21, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hosp., Olney				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Montg. Sandy Spring					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18301 Brooke Road		
14. FATHER'S NAME FIRST MIDDLE LAST Lewis Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irie Lee Williams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT ADDRESS Carrie Mitchell (Sister) 640 D Street, N.E. Wash. D. C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Intravascular Coagulation 6 hr 4590 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiogenic Shock 12 hr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Acute myocardial infarction 12 hr									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Severe chronic alcoholic liver disease									
19a. DATE OF OPERATION 12/2/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intra abd. bleeding			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June , 19 79 , to Dec 2 , 19 79 , that (I) (we) last saw the deceased alive on Dec 2 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Catherine M. Chura, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/3/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-79		23c. NAME OF CEMETERY OR CREMATORY Mutual Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden					24b. ADDRESS 246 N. Washington Street Rockville, Md. 20850		24c. DATE REC'D. BY REGISTRAR DEC 6 1979		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR 1 - STATE REGISTRAR					7 9 3 1 1 9 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Fannie P. Brown					2a. DATE OF DEATH MONTH DAY YEAR December 15, 1979			2b. HOUR 5:17am	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10-23-1886		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher (retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.					13b. CITY OR TOWN Gaithersburg		13c. STREET ADDRESS 7466 Brink Road		
14. FATHER'S NAME FIRST MIDDLE LAST Shadrack Riggs					15. MOTHER'S MAIDEN NAME FIRST LAST Mary Duffin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-42-2621		17. INFORMANT ADDRESS Thelma Prather 7470 Brink Rd, Gaithersburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) A-S.H.D. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Seconds									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1947 , 19____, to 12-15 , 19 79 , that (I) was last saw the deceased alive on 12-2-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.									
23a. SIGNATURE Jack Schumacher M.D. DEGREE					23b. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23c. DATE SIGNED 12-15-79	
24. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.					25. ADDRESS 105 Russell Ave., Gaithersburg, Md. 20760				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-18-79		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville, Montg. Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden					24b. ADDRESS 246 N. Washington Street Rockville, Md. 20850		25a. DATE RECEIVED BY REGISTRAR DEC 24 1979		

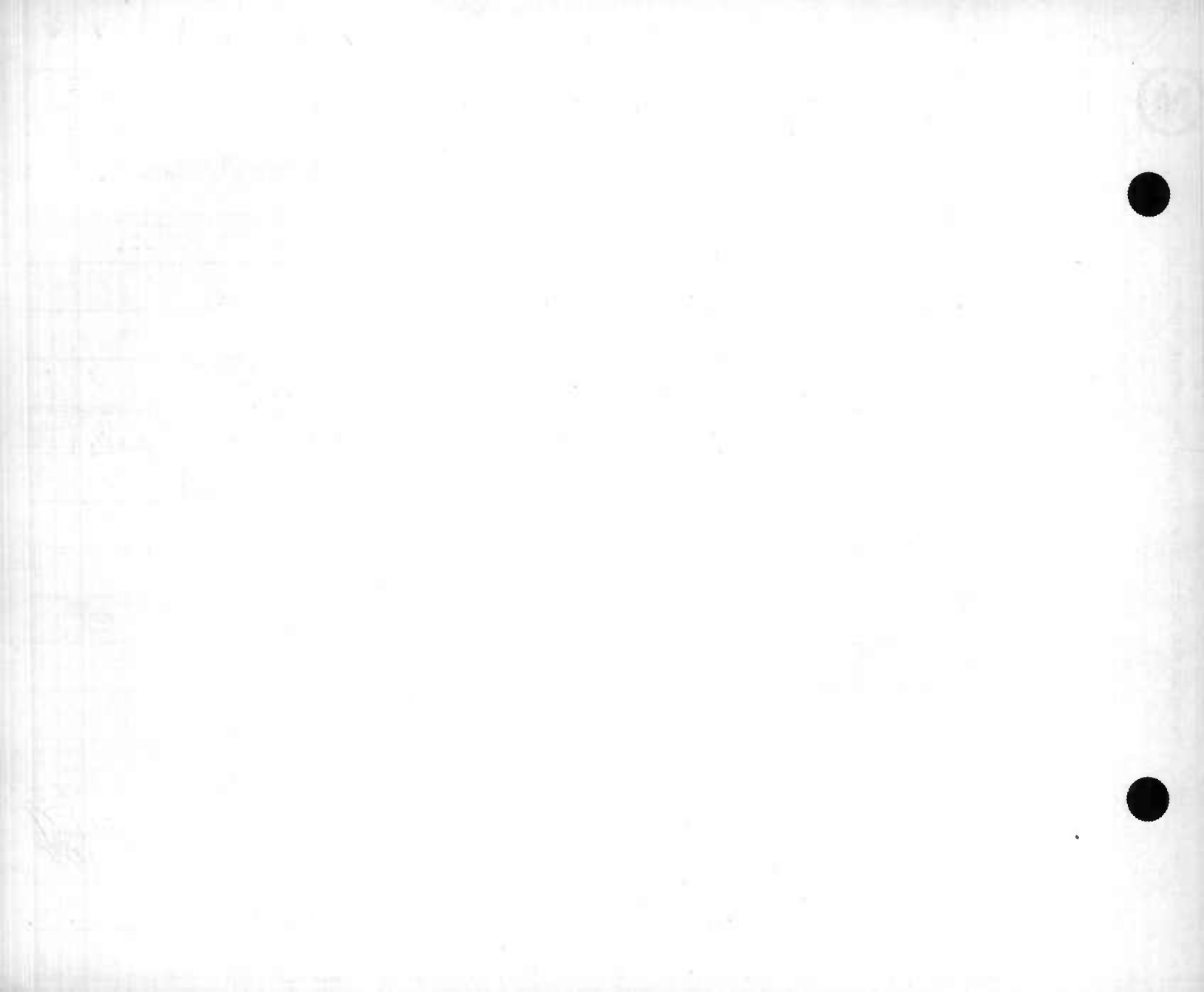
1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					7 9 3 1 1 9 4				
1. DECEASED NAME					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR				
FANNY — BROWN					12-29-79				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		Caucasian		MONTH DAY YEAR		85		10:30 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MONTHS	
Russia		USA				Montgomery		DAYS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. HOURS	
Kensington		Kensington Garden Nur. Home		Housewife		----		MIN.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					13e. STREET ADDRESS				
Md. Montgomery Silver Spr.					12604 Eastbourne Drive				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Isaac Wexler					Rachel Olansky				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
No					348-20-5429				
17. INFORMANT					ADDRESS				
Newton Browning					Harrison, N. Y. 470 Halstead Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i>									
4370 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chn. A.S., Cerebrovascular insuff. years.</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Peripneumonia</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Peripneumonia</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 12/29/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
Abraham Danish						M.D.		12/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
						1106 Spring St. N.Y.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			Jan. 2, '80		Sharon Garden		Valhalla		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS									
Danzansky-Goldberg Inc. Rockville, Md			JAN 2 1980						

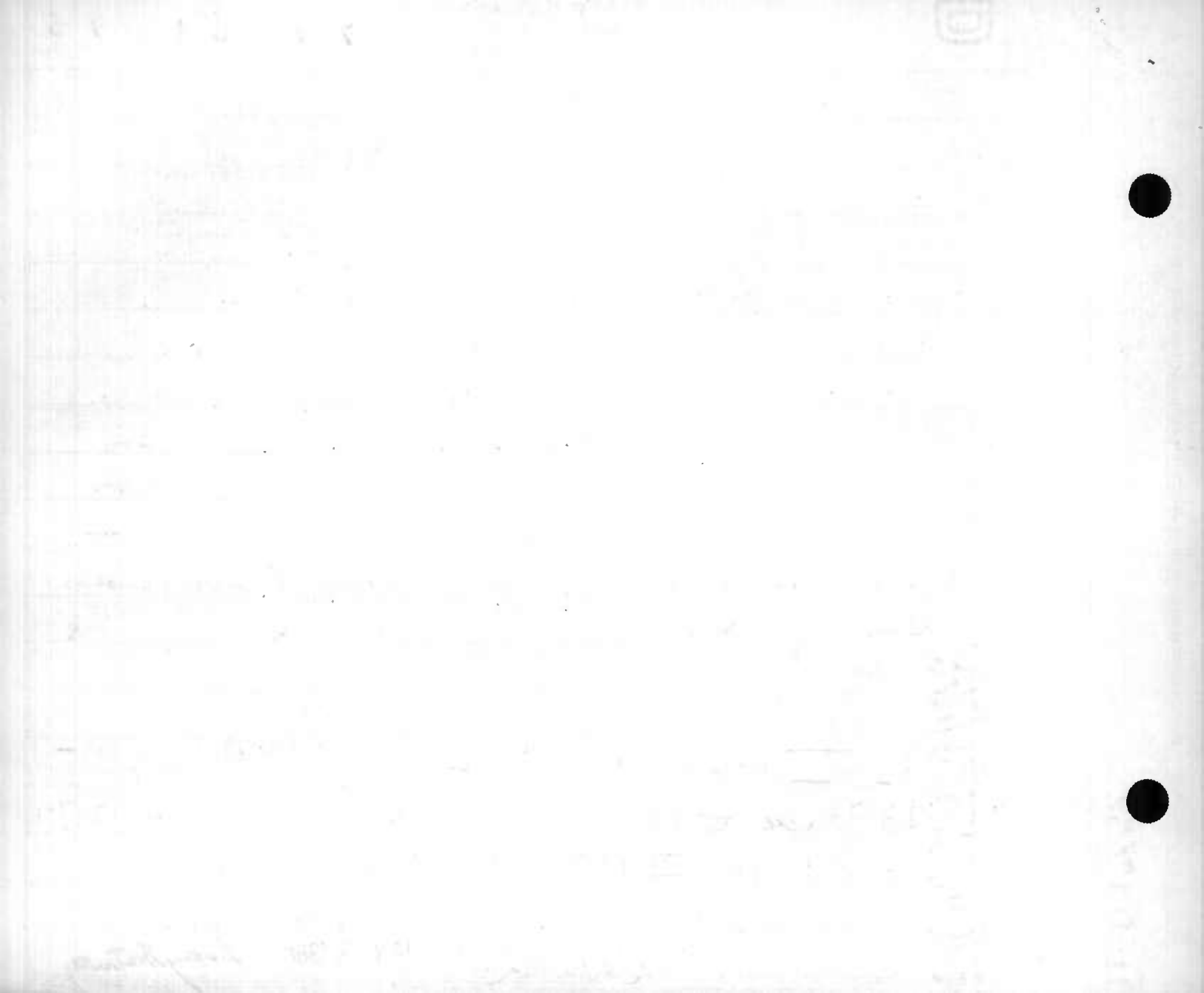


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 1 9 5	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Frank			Brown			12-13-79			1:20 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		3-21-00		79					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		Holy Cross Hospital				Products			John Hopkins		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Sil. Spr.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10000 Brunswick Avenue,			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William Brown				Mary McGrail							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				none		165-03-9239		Harrison Funeral Service, Penna.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Renal Failure</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <u>Liver Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>10 yrs</u> <u>2 mo</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
<u>Permanent Demand Pacer, ASCVD, Anemia, Pulmonary Embolus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
None		None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
No		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> , 19____, to <u>12-13-79</u> , 19____, that (I) (not) lost saw the deceased alive on <u>12-12-79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE						22c. DATE SIGNED					
<u>G B Patrick III MD</u>						<u>12-13-79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
<u>G B Patrick III MD</u>						<u>9321 Colesville Rd Silver Spring, Md. 20910</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12-19-79		St. Thomas Cemetery		Archbald Lackawanna Pa.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Walter E. Pumphrey, Inc.</u>						<u>JAN 16 1980</u>		<u>Walter E. Pumphrey</u>			
<u>8434 Ga. Ave., S.S. Md.</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

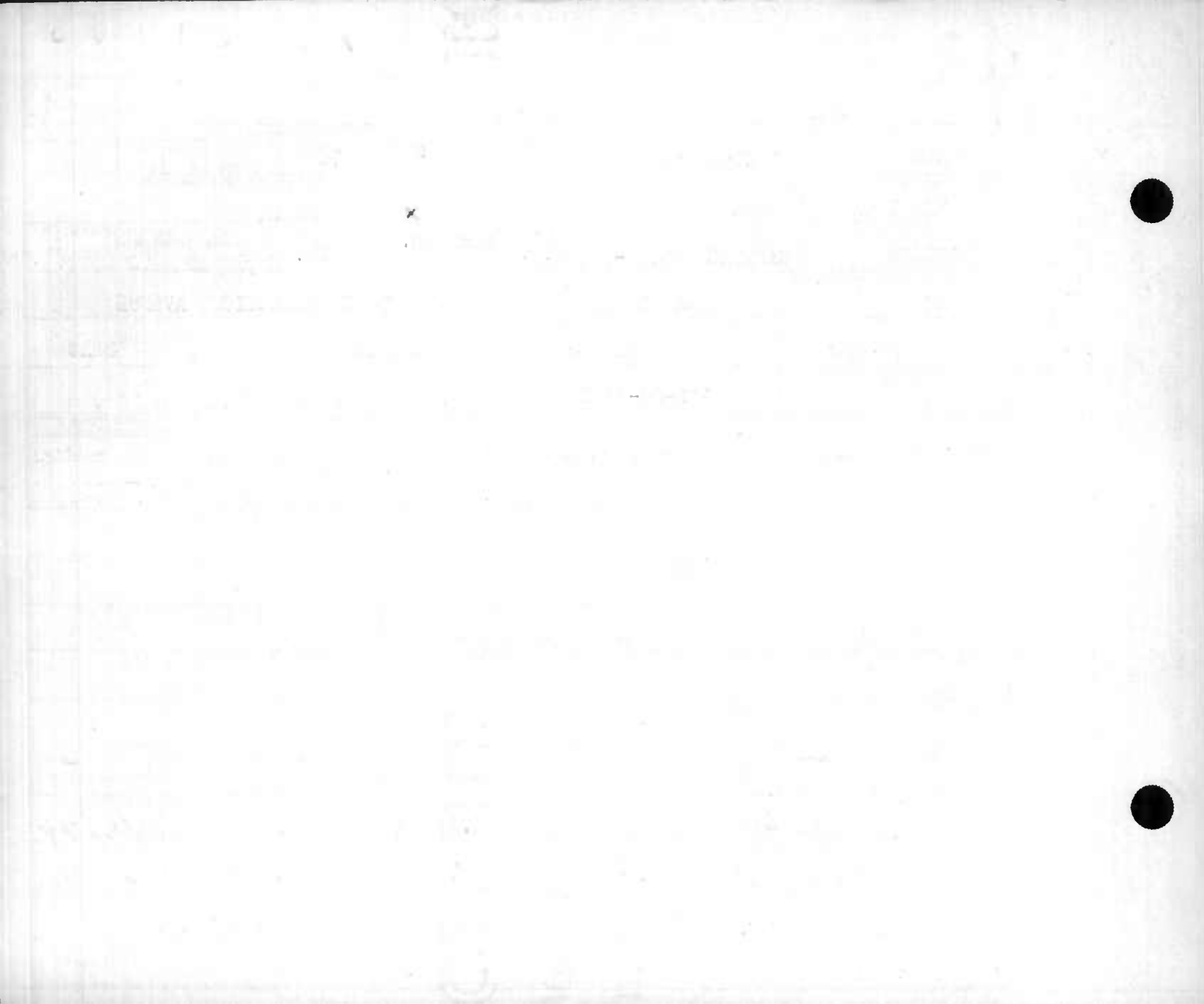
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2r. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
JEAN		CANTOR						12		15	79	10:25	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		C AUCASIAN		MONTH 7 DAY 4 YEAR 03		76		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
NEW YORK		USA				MONTGOMERY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BETHESDA		CARRIAGE HILL - BETHESDA		5215 Cedar Ln.		GOVT. Employee		US Govt.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
DC		WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3801 CONNECTICUT AVENUE							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
MORRIS		CANTOR		TILLIE		BLACK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		102-09-4522		Charles Levine; Box 329; Seville, Fla.									
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>										6 mos			
1830 } DUE TO, OR AS A CONSEQUENCE OF										1 1/2 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) <u>Primary Carcinoma of Ovary</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
7/78										Ovarian Carcinoma			
20a. AUTOPSY?										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY			
										HOUR A.M. MONTH DAY YEAR			
										P.M. 19			
21d. INJURY OCCURRED										21e. PLACE OF INJURY			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION										CITY OR TOWN			
										COUNTY			
										STATE			
22a. I certify that (I) (the hospital) attended the deceased from 12-7-79, to 12-15-79, that (I) (we) lost													
saw the deceased alive on 12-14-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE										DEGREE			
James W. Egan										M.D.			
22c. PHYSICIAN'S NAME (TYPE OR PRINT)										22d. ADDRESS			
JAMES W. EGAN										5413 Cedar Ln - Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE			
Burial										Dec. 18, '79			
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION			
Adas Israel Cemetery										Washington, D.C.			
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR			
NAME ADDRESS										25b. REGISTRAR'S SIGNATURE			
Danzansky-Goldberg Chapels; 1170 Rockville Pike										DEC 24 1979			
										History McCreedy			

BP

DHMM-16 20M
(VRA 15, 4) 7/78



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR Items 18c. & 22a. 1- STATE Film#G539 1-24-80 REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		31197 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Beatrice K. Carpenter		2a. DATE KNOWN OF DEATH ESTIMATED 12 8 19 79		2b. HOUR 12 P M	
3. SEX female	4. RACE w	5. DATE OF BIRTH MONTH DAY YEAR 01 03 90	6. AGE YEARS MONTHS DAYS 89 3 2	7. IF UNDER 1 YR. MONTHS DAYS	7. IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STATE Maryland		13b. COUNTY Montgomery	
13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8000 Park Overlook Dr	
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Kinne		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Morse		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 267305532		17. INFORMANT son David J. Carpenter-same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 888 - IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Respiratory Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF <u>verified</u> (c) <u>Coronary Artery Atherosclerosis.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Fracture of Left Hip</u>					
19a. DATE OF OPERATION 12-8-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Repair of Hip Fracture</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 4 P.M. 12-5 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Fall when shopping at Montgomery Mall</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Shopping Mall</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Democracy Ave Bethesda Mont Md</u>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <u>verified</u>					
ACTUAL SIGNATURE <u>John M. Ball</u>		TITLE (SPECIFY) M.D. <u>DePoty</u>		DATE SIGNED <u>Dec. 8, 1979</u>	
EXAMINER'S NAME (TYPE OR PRINT) John M. Ball, MD		ADDRESS <u>7936 Old Georgetown Rd Bethesda, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-11-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Va.	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va.		24. FUNERAL DIRECTOR NAME ADDRESS Pearson's Funeral Home 472 N. Wash. St., Falls Church, Va.		25a. DATE REC'D. BY REGISTRAR DEC 13 1979	
25b. REGISTRAR'S SIGNATURE <u>John M. Ball</u>					

Section 1. General

ST 03 00 00

Suburban Hospital

Section

8000 Park Overlook Dr

Montgomery, Md 20854

Section

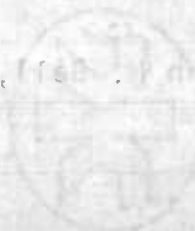
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minutes

over

XXXXXX 7925 011
Section, 1

John F. 1971, MD



XXXXXX 7925 011



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				79 31 198			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Sonia Chess				MONTH DAY YEAR 12 12 '79			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR August 15, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH Cherry Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Nursing Retirement		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND				13b. CITY OR TOWN KENSINGTON		13c. STREET ADDRESS 3208 WAKE DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST (UNASCERTAINABLE)				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNASCERTAINABLE)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO 318-30-2398		17. INFORMANT IDA LERISH, same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 4140 Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c):				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (a) (the hospital) attended the deceased from December 12/11 1979 to 12/12 1979 that (we) last saw the deceased alive on 12/11 1979 and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.				23. SIGNATURE J. Blaine Fitzgerald, MD		23b. DATE SIGNED 12/12/79	
24. PHYSICIAN'S NAME (TYPE OR PRINT) J. BLAINE FITZGERALD, MD				24a. ADDRESS 8218 Wisconsin Ave Bethesda			
25a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		25b. DATE 12/14/1979		25c. NAME OF CEMETERY OR CREMATORY LOMZER CEMETERY		25d. LOCATION CITY OR TOWN COUNTY STATE FOREST PARK, COOK, ILLINOIS	
26. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET N.W. WASHINGTON, D.C.				26a. DATE REC'D. BY REGISTRAR DEC 17 1979		26b. REGISTRAR'S SIGNATURE [Signature]	



RECEIVED
JUL 11 1958
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C. 20535

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 7/11/58

BY: [Illegible]

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMM - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NICK FRANK CIFFOLILLI						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 12 26 79		2b. HOUR <input type="checkbox"/> MIN <input type="checkbox"/> SEC <input type="checkbox"/> 11:40			
3. SEX male		4. RACE white		5. DATE OF BIRTH 1920 6 27		6. AGE (IN YEARS) 59		7. IF UNDER 1 YR. <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> HOURS <input type="checkbox"/> MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Elec. Engr.		12b. KIND OF BUSINESS OR INDUSTRY Terminal	
13a. STATE Maryland						13b. CITY OR TOWN Beltsville		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13d. STREET ADDRESS 11003 Brandon Ln.	
14. FATHER'S NAME FIRST Domenico M. MIDDLE Ciffolilli LAST Ciffolilli						15. MOTHER'S MAIDEN NAME FIRST Filomena MIDDLE M. LAST Caramanco					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 579-07-8325		17. INFORMANT ADDRESS Maria J. Ciffolilli - above address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis (c) (Wife)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Rogers						TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER		DATE SIGNED Dec 27/79	
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/31/79		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.			
24. FUNERAL DIRECTOR NAME Nalley's F. H. Inc. ADDRESS Mt. Rainier, Md.						25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE John Rogers			

NICK FRANK CIRCILLI

male white 5' 10" 150 lbs

x

U.S.A.

Tolson Park Washington Ventral Hospital

Maryland 20 Baltimore 11003 Brandon Ln.

11003 Brandon Ln.

U.S.A.

Washington

11003 Brandon Ln.

U.S.A.

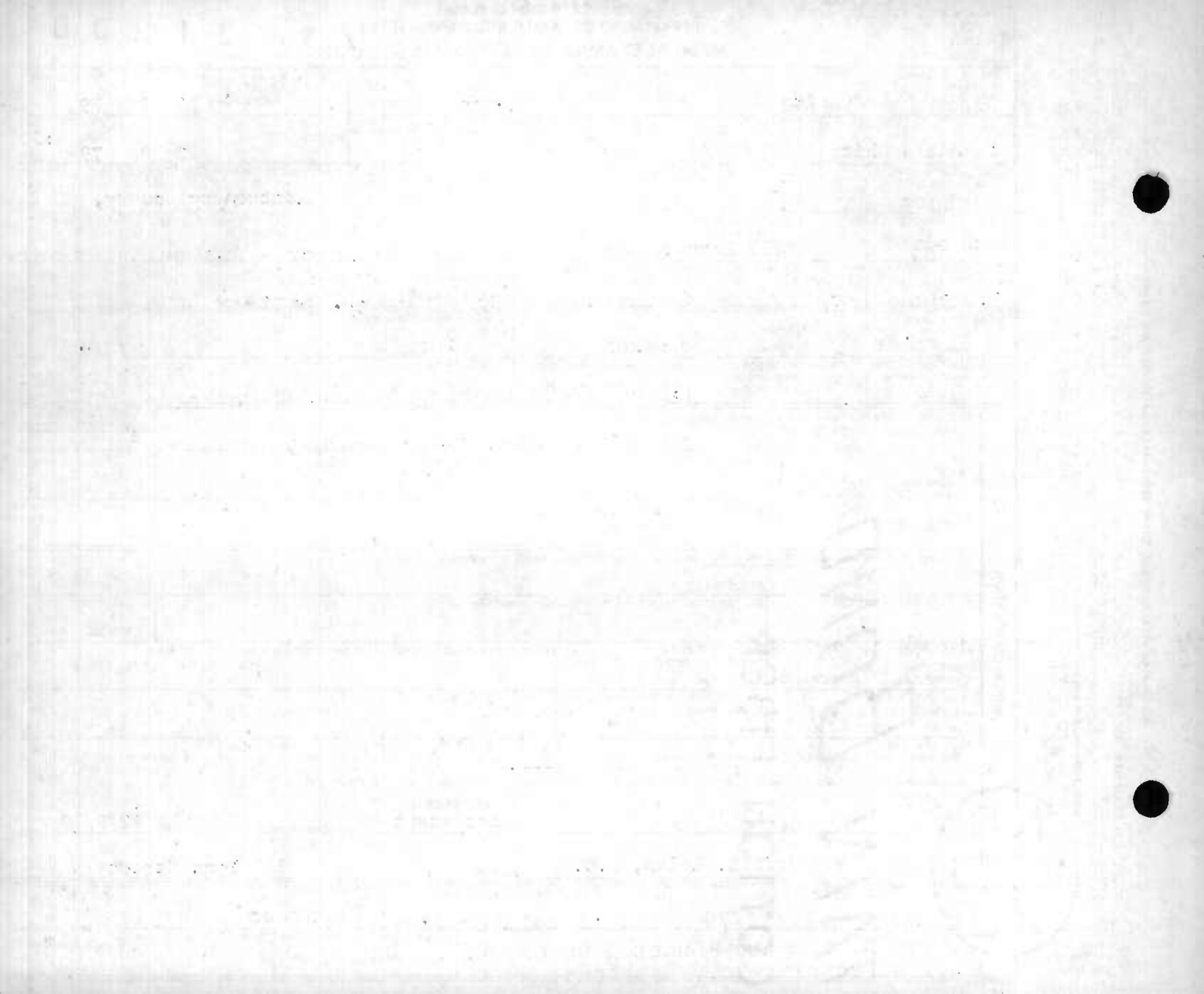
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

31200

1. DECEASED NAME (TYPE OR PRINT) Clara Juanita Claxon		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 7 19 79		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1/24/17	6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. XX
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4977 Battery Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager - Answering Service
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Claxon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Carter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-05-7876		17. INFORMANT ADDRESS 6016 Cheshire Dr. Bethesda, MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Emphysema				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Virginia L. Dolan		TITLE (SPECIFY) Assistant		DATE SIGNED 12/9/79
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/12/79	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey, P.A. 7557 Wisconsin Ave., Bethesda, MD		25a. DATE REC'D. BY REGISTRAR DEC 12 1979		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 2 0 1

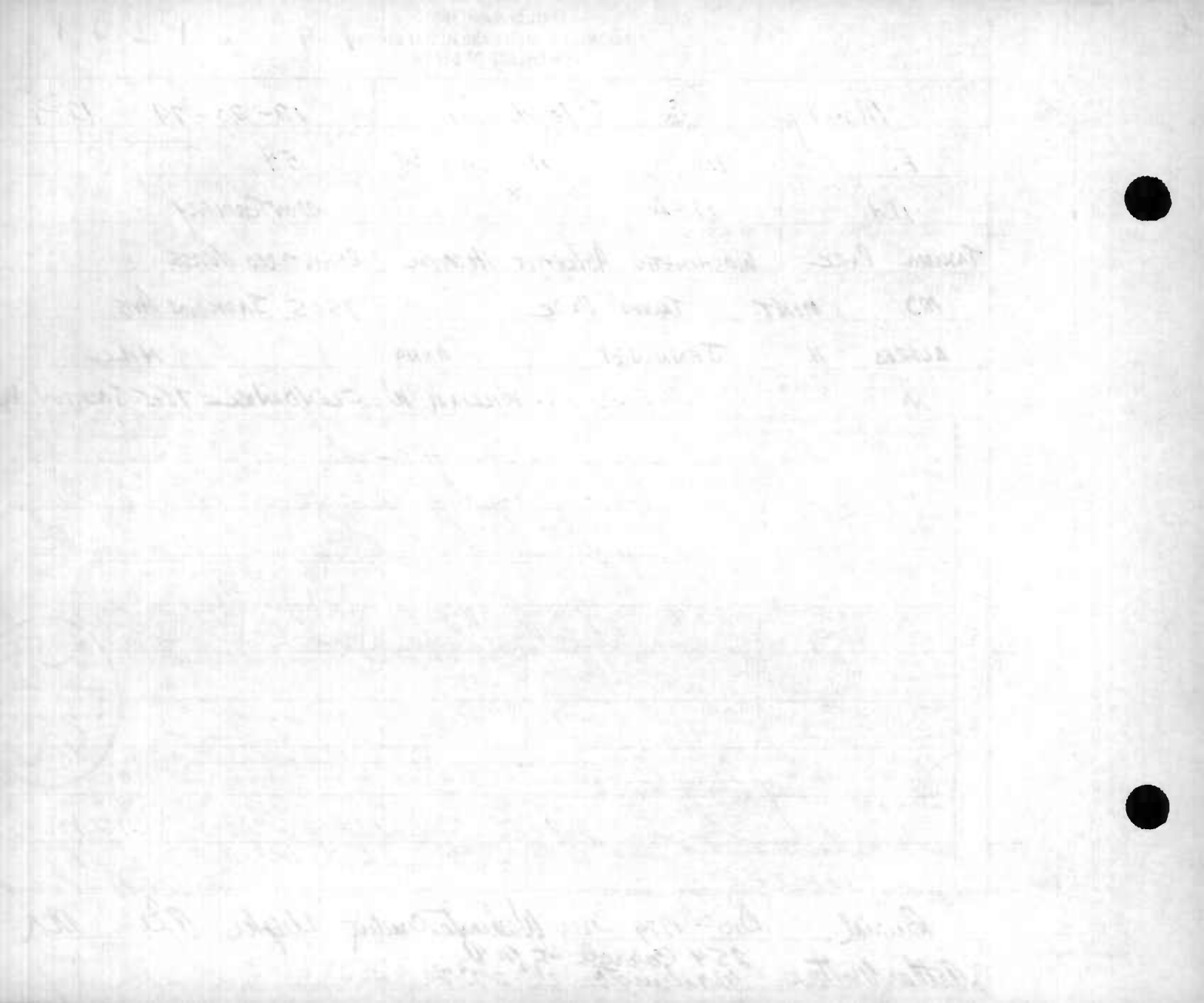
1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Marilyn E. Clendaniel</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-20-79</i>		2b. HOUR <i>12³⁵ PM</i>
3. SEX <i>F.</i>	4. RACE <i>W.</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11-24-25</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>54</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.	
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>REGISTERED NURSE</i>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i> 13b. COUNTY <i>MONT.</i> 13c. CITY OR TOWN <i>TAKOMA PARK</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>7505 JACKSON AVE</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>ALFRED H. JENNINGS</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNA HILL</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>545-42-2644</i>		17. INFORMANT ADDRESS <i>WILLIAM W. CLENDANIEL - 7505 JACKSON AVE</i>

11. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b1, and 1b2) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive angina</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Spontaneous rupture of aorta</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Pharyngeal obstruction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):		

19a. DATE OF OPERATION <i>12/14/79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Pharyngeal obstruction</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 19, PART 1 OR PART 2)	
21d. INJURY OCCURRED: WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION FIRST CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/14/79</i> to <i>12/20/79</i> that (I) (we) did (saw) the deceased (died) (did not) view the body after death.					
22b. SIGNATURE <i>H.L. Marter</i> DEGREE <i>M.D.</i>				22c. DATE SIGNED <i>12/20/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H.L. MARTER</i>				22e. ADDRESS <i>531 University Blvd E. Silver Spring, MD</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Dec 24 1979</i>	23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Alexandria VA</i>
24. FUNERAL DIRECTOR NAME <i>Arthur Walters</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 27 1979</i>	25b. REGISTRAR'S SIGNATURE <i>Robert J. [Signature]</i>





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dollie Lynette Collins			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1979		2b. HOUR 9:10A.M.		
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 3 2 1912		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg	
14 FATHER'S NAME Wiley		15 MOTHER'S MAIDEN NAME Morrison Neff		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 447 W. Diamond Ave. #101	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216 36 7227		17 INFORMANT Charlotte V. Collins same as 13e		ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sigmoid carcinoma, recurrent</u> 1719 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1967
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION 11/6/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Chromial Sigmoid carcinoma		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 10/22/79 to 12/24/79, that (I) (we) lost saw the deceased alive on 12/24/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE John G. Lodmell				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Lodmell				22e. ADDRESS 18111 Prince Phillip Dr. Olney, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/79		23c. NAME OF CEMETERY OR CREMATORY Neff Family Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rosehill, Virginia	
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				25a. DATE RECEIVED BY REGISTRAR JAN 2 1980			
				25b. REGISTRAR'S SIGNATURE			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 31203			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Charles		C		Columbus				12		20	79	11 ¹⁰	A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
male		white		NOV. 30 1902		77		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
WASHINGTON, D.C.		USA				Mont.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross		BUDGET ANALYST		U. S. GOV'T.							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input type="checkbox"/> NO <input type="checkbox"/>		203 ST. LAWRENCE					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
ARCHIBALD		C. COLUMBUS		LAURA		WILLIAMS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		WIFE		ADDRESS					
NO		579-12-1211		CATHERINE V. COLUMBUS		SAME AS 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u>													
4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Pulmonary infarct</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio sclerotic Cardiovascular</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 2</u> , 19 <u>79</u> , to <u>Dec 20</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Dec 20</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Bernard A. Fitzgerald MD						12-20-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
BERNARD A. FITZGERALD		217 UNIVERSITY BLVD E, SILVER SPRING, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		DEC. 22, 1979		GATE OF HEAVEN		SILVER SPRING MONT MD							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
FRANCIS J. COLLINS		500 UNIVERSITY BLVD., W. SILVER SPRING, MD		DEC 26 1979		R. J. McBrady							

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1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a very interesting and informative account of the work done and the results obtained. The second part of the report deals with the specific work done during the year. It is a very detailed and thorough account of the work done and the results obtained. The third part of the report deals with the financial statement of the year. It is a very clear and concise statement of the financial position of the organization. The fourth part of the report deals with the recommendations for the future. It is a very thoughtful and practical set of recommendations for the future. The fifth part of the report deals with the conclusions of the year. It is a very brief and concise summary of the year's work.

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a very interesting and informative account of the work done and the results obtained. The second part of the report deals with the specific work done during the year. It is a very detailed and thorough account of the work done and the results obtained. The third part of the report deals with the financial statement of the year. It is a very clear and concise statement of the financial position of the organization. The fourth part of the report deals with the recommendations for the future. It is a very thoughtful and practical set of recommendations for the future. The fifth part of the report deals with the conclusions of the year. It is a very brief and concise summary of the year's work.



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 2 0 4

1. DECEASED NAME (TYPE OR PRINT) William Leader CONLEY			2a. DATE OF DEATH MONTH DAY YEAR December 29 1979			2b. HOUR 9:20P M				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 18 1917		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Commander		12b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12702 Veirs Mill Road	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Martin Conley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Leader							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1941-67		17. INFORMANT Mrs. Mary B. Conley		17. ADDRESS See item 13				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic broncho-alveolar carcinoma 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from Dec. 5, 1979, to Dec. 29, 1979, that (1) (we) lost above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE George T. Gamblin M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Dec. 31, 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George T. Gamblin, M. D.						22e. ADDRESS National Naval Medical Center, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-4-80		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home, Bethesda, Md.						25a. DATE REC'D. BY REGISTRAR JAN 4 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Blank lined paper with horizontal ruling lines and two binder holes on the right side.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 0 5

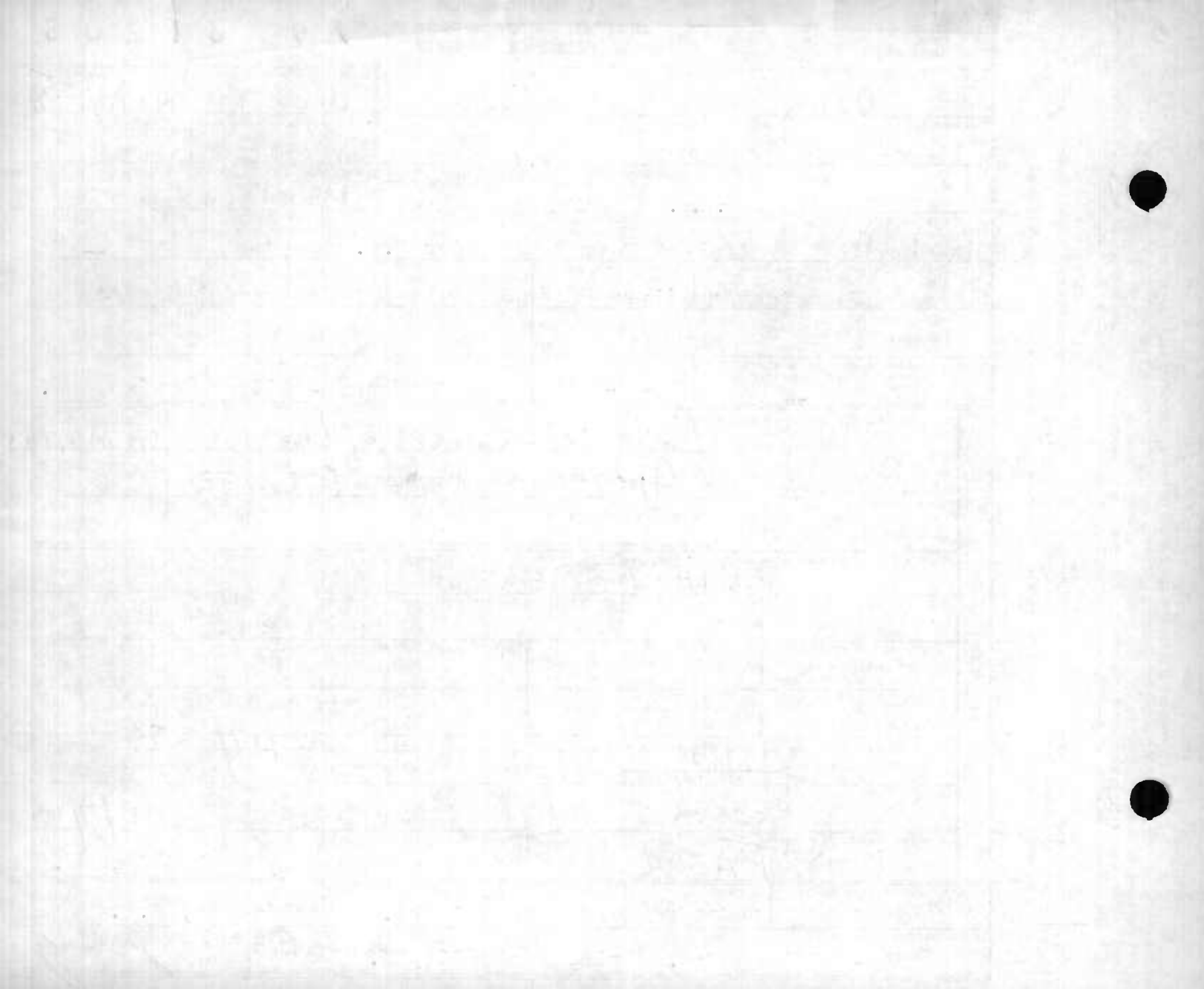
1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Celia		FIRST C		MIDDLE O		LAST RDOVER		2a. DATE OF DEATH MONTH DAY YEAR Dec. 17th 1979		2b. HOUR 1:20 PM	
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR August 4 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater D.C. Homemaker						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY FAVELSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH PRESSMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 578-34-0387 D		17. INFORMANT ADDRESS Erma Cordover - Silver Spring, Md.							
18. CAUSE OF DEATH (Enter only one cause per item for 1a), 1b), and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer of Liver 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c) -- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SIX MONTHS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) SENILE DEMENTIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 11/7/79 to 12/17/79 , that (I) (we) last saw the deceased alive on 12/17/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) certify body after death.											
22b. SIGNATURE D.D. Patel		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/17/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL		22e. ADDRESS 6121 Montrose Rd., Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/19/79		23c. NAME OF CEMETERY OR CREMATORY Adas Israel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.					
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Mem. Chpls, Rockville, Md.						25a. DATE RECEIVED BY REGISTRAR DEC 24 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



Alphonse Cronin

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 7 9 3 1 2 0 6							
1 DECEASED NAME (TYPE OR PRINT)		FIRST ROBERT		MIDDLE E	LAST CRONIN		2a DATE OF DEATH		2b HOUR
ROBERT		White		Dec. 31 1903		75		12 9 79 5:30 PM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
				MONTH DAY YEAR		75 YRS		Illinois	
				MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				7b CITIZEN OF WHAT COUNTRY? U.S.A.	
								9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17b KIND OF BUSINESS OR INDUSTRY			
		Potomac Valley Nursing Home		Professor (Ret)		University			
13a STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 5506 Christy Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Timothy Joseph Cronin		Margaret Mary Howe							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
Yes		WW2 & Korea		320-34-7051		Carolyn Jane Cronin, Wife. Same as item 13.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Reported Cerebrovascular Accident</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (this hospital) attended the deceased from <u>2-17</u> 19 <u>76</u> to <u>12-9</u> 19 <u>79</u> that (I) (we) lost saw the deceased alive on <u>11-24-79</u> 19 <u>79</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.		22b SIGNATURE <u>W H Killay MD</u>		22c DATE SIGNED <u>12-9-79</u>					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
W H Killay MD		Robert Poddar MD		Bethesda Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		STATE	
Burial		12/13/1979		U.S. Naval Academy Cem.		Annapolis, Maryland.			
24 FUNERAL DIRECTOR		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Joseph Gawler's Sons, Inc.		DEC 14 1979		<u>Robert Poddar</u>					
5130 Wisconsin Ave., Wash. D.C.									

100

Figure 1. Schematic representation of the experimental design. The subjects were divided into two groups: the control group and the experimental group. The control group was divided into two subgroups: the control group and the experimental group. The experimental group was divided into two subgroups: the control group and the experimental group. The control group was divided into two subgroups: the control group and the experimental group. The experimental group was divided into two subgroups: the control group and the experimental group.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7931207	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) MELVIN EUGENE CUNNEFF				2a. DATE OF DEATH MONTH 12 / DAY 17 / YEAR 79		2b. HOUR 7⁴⁰ A.M.			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH 6 / DAY 12 / YEAR 25		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS 		8 IF UNDER 24 HRS HOURS MIN. 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY, County MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY delivery Central			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Montgomery 13c CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7011 Clarendon Road, #1					
14 FATHER'S NAME FIRST Thomas MIDDLE LAST Cunneff				15 MOTHER'S MAIDEN NAME FIRST Bertha MIDDLE LAST Roberts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 278-28-6951		17 INFORMANT ADDRESS Norma F. Cunneff, same as #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE										2 months	
DUE TO, OR AS A CONSEQUENCE OF (c) EXTENSIVE ANTERIOR MYOCARDIAL INFARCT										2 mo	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 11/10/79 to 12/17/79 , that (2) (we) lost 12/16/79 above, and that in my (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE Robert Stevenson, Jr MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED 12/17/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER STEVENSON, JR MD				22e. ADDRESS 11125 ROCKVILLE PIKE ROCKVILLE, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/18/79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia					
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A.						25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE Lutley McCreedy			
26 ADDRESS 7557 Wisconsin Ave., Bethesda, MD											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Win Fred E. DAVIS			2a. DATE OF DEATH MONTH December DAY 28 YEAR 1979			2b. HOUR 9:00 P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 10 DAY 15 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pest Control		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. 13c. COUNTY Montgomery 13d. CITY OR TOWN Gaithersburg			13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13f. STREET ADDRESS #6 Peony Dr.			
14. FATHER'S NAME FIRST William G. MIDDLE Davis LAST 			15. MOTHER'S MAIDEN NAME FIRST Nellie MIDDLE Phebus LAST 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-03-8590			17. INFORMANT ADDRESS Catherine Davis-wife #6 Peony Dr. Gaithersburg			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Negative Sepsis & Shocks 5621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Peritonitis from Biliary Fistula (c) Peritonitis from Ruptured Diverticulum & Massive G.I.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours 1 week 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Renal failure, Hypertension, Aspiration Pneumonia									
19a. DATE OF OPERATION 11/23/79; 12/2/79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Signed Diverticulum GI Bleed			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from September 19 79 , to December 19 79 , that (I) was lost saw the deceased alive on Dec 28 19 79 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.									
22b. SIGNATURE Patricia Deal Kellogg DEGREE MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA DEAL KELLOGG						22e. ADDRESS 809 Vicks Mill Rd, Rockville, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-30-79		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002			
24. FUNERAL DIRECTOR NAME Lee Funeral Home ADDRESS 300-4th St. N.E. Wash. D.C.				25a. DATE REG'D BY REGISTRAR JAN 8 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

Operation

12-30-79

Lee's Crematory

Washington, D.C. 20005

Lee Funeral Home 300 4th St. N.W. Wash. D.C. 20005

No

None

577-03-8-90

Catherine Davis-Wile & Perry Dr. Galther

William G. Davis

Kellie Inebus

Mr.

Montgomery Galther

x

& Perry Dr.

Bedstead

Robinson Hospital

Pest Control

USA

Montgomery

x

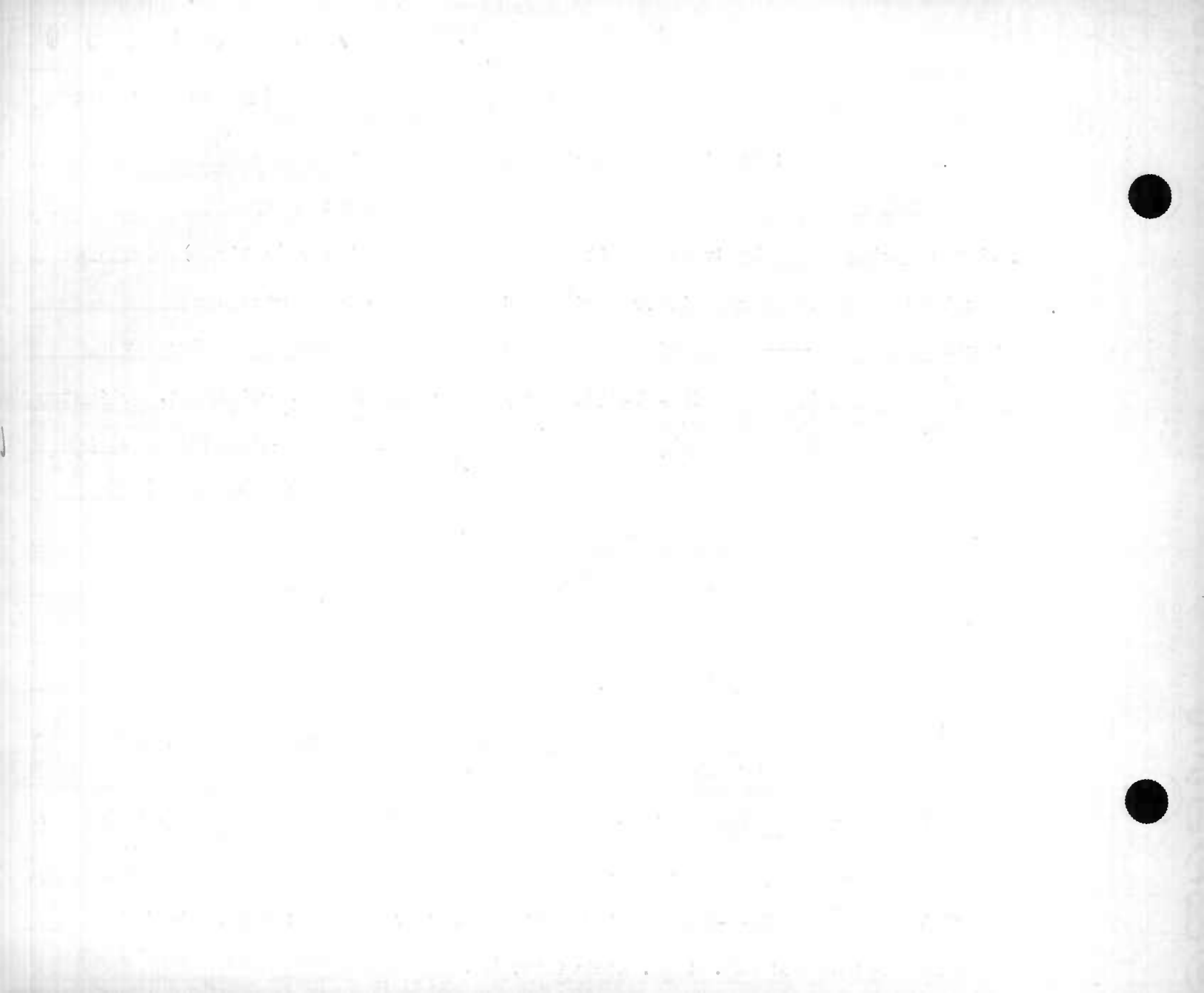
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 0 9 REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) ABRAHAM J DAVISON						2a. DATE OF DEATH MONTH DAY YEAR 12 4 79		2b. HOUR 8:30 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 18, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer (retired)		12b. KIND OF BUSINESS OR INDUSTRY Newspaper			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1400 Fenwick Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Louis ----- Davison				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bryna ----- Karasov							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Gene Davison				ADDRESS 2377 N. Quincy St. Arlington, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic left ventricular failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 Day 10 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-1-79 19 79 , to 12-4 19 79 , that (I) (we) last saw the deceased alive on 12-4 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Herbert L. TANENBAUM						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-4-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert L. TANENBAUM						22e. ADDRESS 5480 Wisconsin Ave Chevy Chase road					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-79		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Gdn.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia					
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.						25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE History McBrady			



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 7 9 3 1 2 1 0			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence E. Dawson					December 3, 1979			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 1/18/1899		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		2b. HOUR 8:15AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.		
10 CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7907 Glendale Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Law
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Chevy Chase					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7907 Glendale Road	
14 FATHER'S NAME FIRST MIDDLE LAST Clarence E. Dawson					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katharine Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17 INFORMANT ADDRESS Adelaide Barker Dawson, same as #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3-19 1979, to 12-3 1979, that (I) (we) lost saw the deceased alive on 11-30 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>William F. Luckett</i>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Luckett, M.D.				22e. ADDRESS 5000 Reno Road N.W. Washington, DC				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/6/79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		
24. FUNERAL DIRECTOR NAME A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Ave., Bethesda, MD				25a. DATE REC'D. BY REGISTRAR DEC 5 1979		25b. REGISTRAR'S SIGNATURE <i>Anthony McCurdy</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 1/76
(VR A 15 (4))



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR			7 9 3 1 2 1 1 REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR			
Jason John De Fauw			December 5, 1979								1:50 ^a				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		August 25, 1974		5 YRS.		MONTHS		DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Georgia		USA				Montgomery county, MD.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Bethesda			Clinical Center (NIH)			N/A			N/A						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Georgia						Savannah			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			616 Valleybrook Road			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS (same as above)			
Rodger De Fauw			Jacqueline Un/k			No			None			287-66-2978 Mr. Roger De Fauw (father)			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 2002 DUE TO, OR AS A CONSEQUENCE OF (b) BURKITT'S LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2SECONDS 10MONTHS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 27, 1979, to Dec. 5, 1979, that (I/we) lost saw the deceased alive on Dec. 5, 1979, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (not) view the body after death.															
22b. SIGNATURE Carol Janus MD										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/5/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROL JANUS										22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md, 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE						
Removal									Savannah Ga						
24. FUNERAL DIRECTOR NAME W.W. Chambers										24b. ADDRESS 8655 Ga., Ave Sil. Spgs		25a. DATE RECEIVED BY REGISTAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

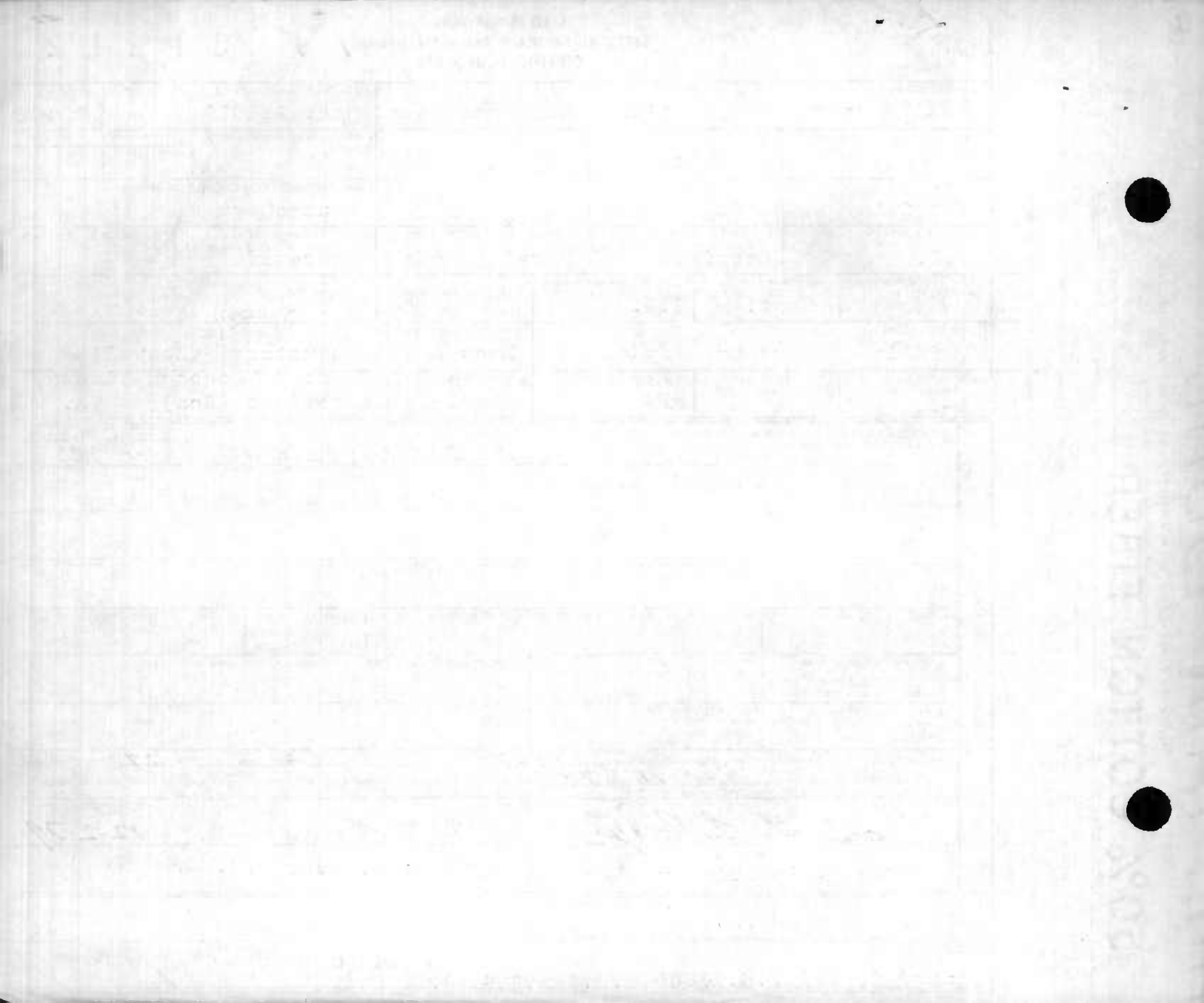
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 7 9 3 1 2 1 2					
1. DECEASED NAME (TYPE OR PRINT) Mattie (Martha) Aileen Dellastatious					2a. DATE OF DEATH MONTH DAY YEAR Dec. 2, 1979			2b. HOUR PM 12:02		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 5 95		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.					13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Arthur Hayden					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Addie Augustus Boswell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 09 5923D		17. INFORMANT 10501 Water Thompson Vienna, Va. Paul Dellastatious (Son)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIOSCLEROSIS</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 YRS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>1968</u> , 19____, to <u>12-2</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>NOV 11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE David G. Luthringer				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-2-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David G. Luthringer				22e. ADDRESS 5530 Wisc. Ave. C.C.Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md.				
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.				11800 N.H. Ave. S.S. Md.		25a. DATE RECEIVED BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]		



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

3 1 2 1 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alice F Denison			2a. DATE OF DEATH MONTH 12 DAY 12 YEAR 79			2b. HOUR 12:03 AM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH May DAY 31 YEAR 1939		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS) Montgomery Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Bank				
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5109 Randolph Road		
14. FATHER'S NAME FIRST Charles MIDDLE LAST Roof				15. MOTHER'S MAIDEN NAME FIRST Lottie MIDDLE LAST Davidson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 032-34-7096		17. INFORMANT ADDRESS Rockville, Md. Linda Kurtz, Sister; 5109 Randolph Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased intracranial pressure 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Brain metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Adenocarcinoma of breast. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 wks 3 mo 1 yr.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) Liver & bone & lymph node metastasis.												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. 		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 						
22a. I certify that (1) this hospital attended the deceased from Aug , 19 79 , to 11 Dec , 19 79 , that (1) was lost saw the deceased alive on 11 Dec , 19 79 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I was not) did not view the body after death.												
22b. SIGNATURE Donald E. Dillon				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12 Dec 79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E. DILLON, M.D.				22e. ADDRESS 18111 Prince Philip Dr., Olney, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-15-1979		23c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery				23d. LOCATION CITY OR TOWN Carysville, Ohio COUNTY STATE 				
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; ADDRESS 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE Kirby						

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 should be retained by the hospital or attending physician.



THE UNIVERSITY OF CHICAGO

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 31214

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GRACE E. DENNY			2a. DATE OF DEATH MONTH DAY YEAR 12-24-79			2b. HOUR 2:03AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 4 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69		7. IF UNDER 1 YEAR MONTHS DAYS 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) P.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST				12a. USUAL OCCUPATION (TYPE OF WORK AND MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY NURSING	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE P.A.			13b. COUNTY NORTHAMPTON		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST FRANK - HYATT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY - BACHMAN			16. STREET ADDRESS 123 NORTH 2ND. STREET			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. W.W.II 195-42-1213		17. INFORMANT 26 WEST CHARLOTTE STREET EDWARD DENNY-MILLERSVILLE, PENNSYLVANIA				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) **Cardiac arrest**

410-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) **Myocardial Infarction acute**
(c) **Artherosclerotic heart Disease.**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Congestive heart failure intractable

19a. DATE OF OPERATION
None

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?
YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **November 28**, 19 **79**, to **December 23**, 19 **79**, that (I) (we) last saw the deceased alive on **December 23**, 19 **79**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
Abraham B. Dabela DEGREE

22c. DATE SIGNED
12/24/79

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ABRAHAM B. DABELA

22e. ADDRESS
4404 Queensbury Rd. Riverdale MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL

23b. DATE
DEC/28/79

23c. NAME OF CEMETERY OR CREMATORY
CALVARY CEMETERY

23d. LOCATION
CITY OR TOWN COUNTY STATE
ALTOONA-BLAIR CO. - PENNSYLVANIA

24. FUNERAL DIRECTOR
NAME
CHAMBERS FUNERAL HOME - RIVERDALE, MARYLAND

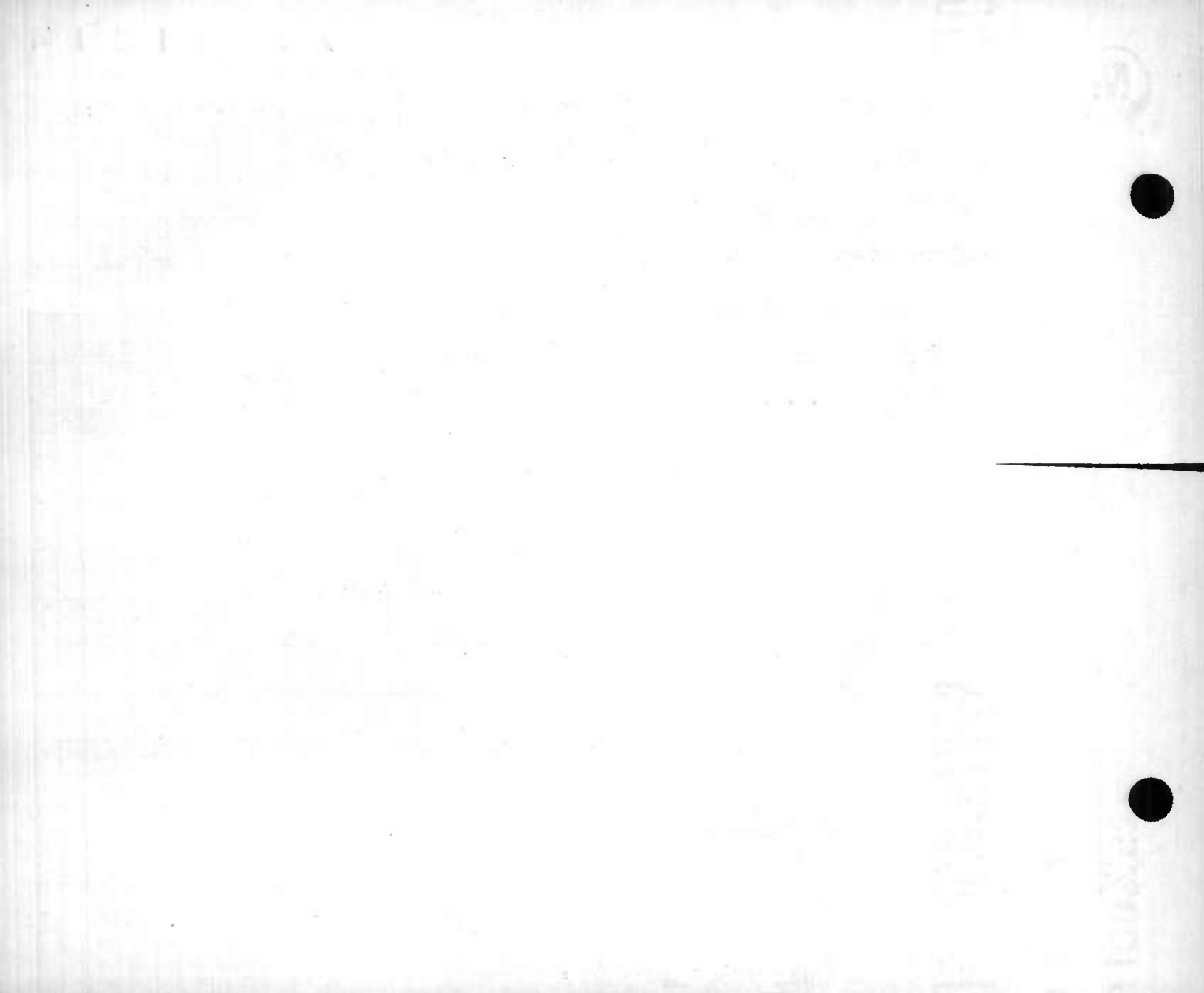
25a. DATE REC'D. BY REGISTRAR
28 1979

25b. REGISTRAR'S SIGNATURE
Robert M. Brady

event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Annie Elizabeth Dorsey</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 4 79</i>		2b. HOUR <i>10⁵⁵ AM</i>								
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 10, 1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>YRS</i>		8. IF UNDER 1 YRS HOURS MIN <i>YRS</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.							
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Md.</i>						13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>710 Roeder Rd. Apt. 104</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>CHARLES WILSON</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>FANNIE CARROLL</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>579-03-7486</i>		17. INFORMANT ADDRESS <i>James Dorsey (husband) same as #13</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days -</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <i>hypertensive cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>with congestive heart failure and renal disease</i>										<i>years -</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Severe anemia, Chronic obstructive pulmonary disease -</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from <i>11/16</i> , 19 <i>79</i> , to <i>12/4</i> , 19 <i>79</i> , that (I) was lost saw the deceased alive on <i>12/4</i> , 19 <i>79</i> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) did <i>did not</i> view the body after death.													
22b. SIGNATURE <i>Robert V. Brennwald</i>						DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/4/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>F.W. BRENNWALD</i>						22e. ADDRESS <i>831 University Ave E, S.S.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>				23b. DATE <i>12-7-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Montg Md.</i>					
24. FUNERAL DIRECTOR NAME <i>George R. Snowden</i>						24b. ADDRESS <i>246 N. WASH. ST.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 11 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert V. Brennwald</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Very respectfully,
Yours very truly,
[Signature]
[Name]
[Title]
[Address]
[City]
[State]
[Country]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 1 6	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>MOZELLE L. DOWNS</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>12 21 79</u>			2b. HOUR <u>5:40 P.M.</u>			
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>MAY 11 1905</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY COUNTY MD.</u>					
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>NATIONAL GUARDIAN</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTG.</u>		13c. CITY OR TOWN <u>ROCKVILLE</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>12600-OLD GEORGETOWN RD.</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>JOHN HAMILTON DOWNS</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ELEANOR ATWELL</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>579-48-8305</u>		17. INFORMANT NAME ADDRESS <u>10 AMAE DOWNS, 1200 OLD GEORGETOWN RD.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unknown</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Bacterial pneumonia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12-6-79</u> , 19 <u>79</u> , to <u>December 21</u> , 19 <u>79</u> , that (I) (was) last saw the deceased alive on <u>December 21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Aaron H. Traum</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>December 21 1979</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>AARON H. TRAUM</u>				22e. ADDRESS <u>8915 Georgia Ave Silver Spring Md 20910</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Dec. 26. 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Bartonsville Md. MD</u>					
24. FUNERAL DIRECTOR NAME ADDRESS <u>Takoma Funeral Home J.A. Walton, 250 Carroll De an</u>				25. DATE RECEIVED BY REGISTRAR <u>DEC 27 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Jeffrey McCreedy</u>					

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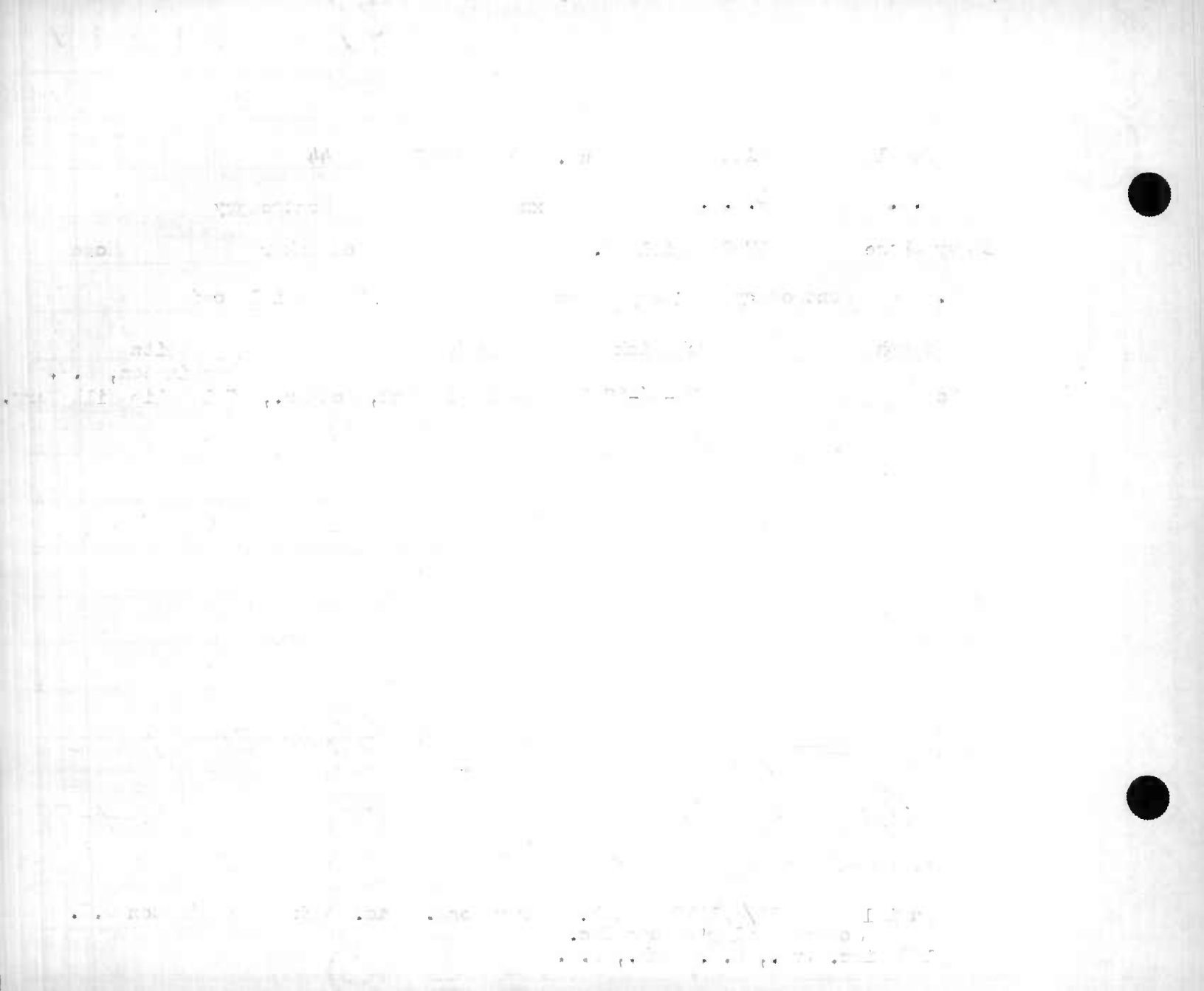
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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 1 7			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Joan						Dubit		12-4-79					12 NOON M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		Aug. 4 1935		44 YRS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
D.C.		U.S.A.				Montgomery						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Chevy Chase		2720 Daniel Rd.		Homemaker		Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>		2720 Daniel Road					
Md.		Montgomery		Chevy Chase									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
Joseph				Schenick		Leah				Deitz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
No				579-46-2762		Leah Schenick, Mother.,		Washington, D.C.		6701 Tulip Hill Terr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) METASTATIC MELANOMA												6 mos.	
1729 DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c) MALIGNANT MELANOMA												5 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				CITY OR TOWN				COUNTY STATE	
22. I certify that (I) (this physician) attended the deceased from JAN. 19 63 to NOV. 30 19 79, that (I) (we) (we) saw the deceased alive on NOV 30 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
Arnold A. Lear M.D.								12-4-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
ARNOLD A. LEAR M.D.				2201 L ST. NW WASHINGTON DC 20037									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial				12/6/1979		Wash. Hebrew Cong. Memo.		Park		Washington		D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
5130 Wisc. Ave., N.W. Wash., D.C.								DEC 7 1979		[Signature]			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND																	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
FOR 1- STATE REGISTRAR		REG. NO. 31218															
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST HERMAN GERARD duBuy						2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR Dec 18 1979		2b. HOUR A M					
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR Oct 3 04 75		6 AGE (IN YEARS) LAST BIRTHDAY YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR Dec 18 1979		2d. HOUR A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HOLLAND		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4504 Delmont Lane				12a. USUAL OCCUPATION (TYPE OF WORK) RESEARCH SCIENTIST - FED. GOVT				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD				13b. COUNTY Mont		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4504 Delmont Lane							
14. FATHER'S NAME FIRST MIDDLE LAST JEAN BERNARD duBuy						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMILIE CAMPHUYS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216-44-6767		17. INFORMANT YVONNE H. duBuy				ADDRESS 11608 MADDOX CT GAITHERSBURG MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4391 Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT)				JOHN S. ROGERS				TITLE (SPECIFY) M.D. 1209				MEDICAL EXAMINER DATE SIGNED Dec 18 1979					
ADDRESS 1919 SEMINOLEY RD. SILVER SP. MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 12/20/79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM				23d. LOCATION CITY OR TOWN SUITLAND - PG. MD.							
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS				ADDRESS SILVER SPRING CG. MD.				25a. DATE REC'D. BY REGISTRAR DEC 20 1979				25b. REGISTRAR'S SIGNATURE [Signature]					

THE UNIVERSITY OF CHICAGO

HERMAN CANNON

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John S. Rogers

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REMARKS: If item 21 is marked on item 18, however, for other traumatic events, including must be noted at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 1 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna C Dunbar</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 24 79</i>		2b. HOUR <i>12 55 PM</i>		
3 SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Jan. 26, 1902</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Missouri</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Exec. Secretary</i>		17b. KIND OF BUSINESS OR INDUSTRY <i>Burroughs Business Mach</i>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <i>Maryland</i>		12b. CITY OR TOWN <i>Montgomery</i>		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <i>10250 Westlake Drive #418</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Jacob Clemens</i>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary A. Wolff</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO <i>216-16-6357</i>	
16c. INFORMANT <i>Ann D. Duchesne</i>		16d. ADDRESS <i>10200 Ridgemoor Dr Silver Spring, MD</i>		17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Exec. Secretary</i>		17b. KIND OF BUSINESS OR INDUSTRY <i>Burroughs Business Mach</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardiogenic shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Atherosclerosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i> <i>hours</i> <i>years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 24</i> 19 <i>79</i> , to <i>Dec 24</i> 19 <i>79</i> , that (I) (<input checked="" type="checkbox"/>) last saw the deceased alive on <i>Dec 24</i> 19 <i>79</i> , and that in (my) (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Harris M. Kenner M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/25/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HARRIS M. KENNER</i>		22e. ADDRESS <i>1040 Old Georgetown Rd Bethesda Md 20814</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/28/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville, Maryland</i>	
24 FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i>		24b. ADDRESS <i>Homes, P.A. Bethesda, Maryland</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 31 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 2 0

REG. NO.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Alice J. Duris		2a DATE OF DEATH MONTH DAY YEAR 12 29 79		2b HOUR AM 8 31 AM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 4 6 06	
6 AGE (IN YEARS LAST BIRTHDAY) 73		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co.		10 CITY OR TOWN OF DEATH Bethesda	
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School teacher		12b KIND OF BUSINESS OR INDUSTRY Education	
13a STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Rockville	
14 FATHER'S NAME FIRST MIDDLE LAST Daniel Moran		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret McKee		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b SOCIAL SECURITY NO. 015 127920		17 INFORMANT Carol Dyer, 6809 Buttermere Lane,		ADDRESS Bethesda, MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute Cardiac Respiratory Arrest (c) Chronic Heart Disease 4 years.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15-20 minutes			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Rheumatic Heart disease - chronic Atrial fibrillation					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e LOCATION STREET CITY OR TOWN COUNTY STATE			
21f CERTIFY THAT (I) (this hospital) attended the deceased from saw the deceased alive on Dec 28 1979 about (I) (did not) view the body after death.		19 75 to Dec 29 19 79		that (I) (some) lost	
22a SIGNATURE J. Blaine Fitzgerald, M.D.		22b ADDRESS 8218 Wisconsin Avenue, Bethesda, MD		22c DATE SIGNED 12/29/79	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1/2/80		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		24 FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS 7557 Wisconsin Ave., Bethesda, MD		25a DATE REC'D. BY REGISTRAR JAN 4 1980	
25b REGISTRAR'S SIGNATURE Anthony McCreedy					

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO. 9 9 3 1 2 2 1					
1. DECEASED NAME (TYPE OR PRINT) Joseph M. Duvall					2a. DATE OF DEATH MONTH DAY YEAR December 25, 1979			2b. HOUR 6:15 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 16, 1885		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					13c. COUNTY Montgomery		13d. CITY OR TOWN Gaithersburg		13e. STREET ADDRESS 24730 Woodfield School Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph M. Duvall					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Penn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-38-3091		17. INFORMANT ADDRESS Anna Mary Pickett, Gaithersburg, Md. 24724 Woodfield School Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic arteriosclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 4-5 days ? years.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cholesterol mass, possibly malignant.</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>12/23</u> , 19 <u>79</u> , to <u>12/25</u> , 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>12/25</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.										
22b. SIGNATURE <u>John G. Lodmell</u> MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/26/79.		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Lodmell, M. D.					22e. ADDRESS 18411 Prince Philip Dr. Olney, MD 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 28, 1979		23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montg. Md.			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.					25a. DATE REC'D. BY REGISTRAR DEC 31 1979		25b. REGISTRAR'S SIGNATURE			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31222	
1- STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) MILDRED LEE MIDDLE DUVALL LAST Duvall						2b. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH Dec 31 1979		2c. HOUR 4:50 PM	
3. FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH MAY 28 1898 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0 IF UNDER 24 HRS. HOURS 0 MIN. 0		2c. DATE PRONOUNCED DEAD Dec 31 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) Suburban	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12d. HOME		12e. H. Wife		12f. Home	
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 17820 Buehlar Road			
14. FATHER'S NAME FIRST Charles MIDDLE - LAST Hawkins		15. MOTHER'S MAIDEN NAME FIRST Maggie MIDDLE - LAST Watkins		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-18-8639-2		17. INFORMANT Charles M. Richards		ADDRESS Laytonsville, Md. 20760	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries Severe										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8147											
DUE TO, OR AS A CONSEQUENCE OF (b) Trauma. Pedestrian-Auto Accident.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 12:56 P.M. MONTH 12 DAY 31 YEAR 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Crossed Street in path of approaching Van			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street				21f. LOCATION STREET Georgia Ave & Spartin CITY OR TOWN Olney COUNTY Mont. STATE MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED Dec 31, 1979			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 3, 1980		23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION CITY OR TOWN Laytonsville COUNTY Mont. STATE MD.			
24. FUNERAL DIRECTOR NAME Francis H. Barber				ADDRESS Laytonsville, Md. 20760				25a. DATE REC'D. BY REGISTRAR JAN 4 1980		25b. REGISTRAR'S SIGNATURE John G. Ball	

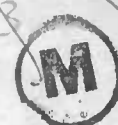




STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 1 2 2 3	
1. DECEASED NAME (TYPE OR PRINT) Robert E. Earhart										2a. DATE KNOWN OF DEATH ESTIMATED 12-31-79	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Mar. 17, 24		6. AGE (IN YEARS) 55 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD December 31, 79	
10. CITY OR TOWN OF DEATH Gaithersburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19315 Clubhouse Road #102				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Industrial Hygienist US		2d. HOUR 9:30 A M	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19315 Clubhouse Road #102	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Earhart						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cecil Bost					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II				16b. SOCIAL SECURITY NO. 281-20-3151		17. INFORMANT ADDRESS Darleen A. Earhart, Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Diabetes Mellitus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John G. Ball</u>				TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 12/31/79					
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd. Beth. MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1-3-79		23c. NAME OF CEMETERY OR CREMATORY CALDWELL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CHILLICOTHE OHIO			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A				ADDRESS ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR JAN 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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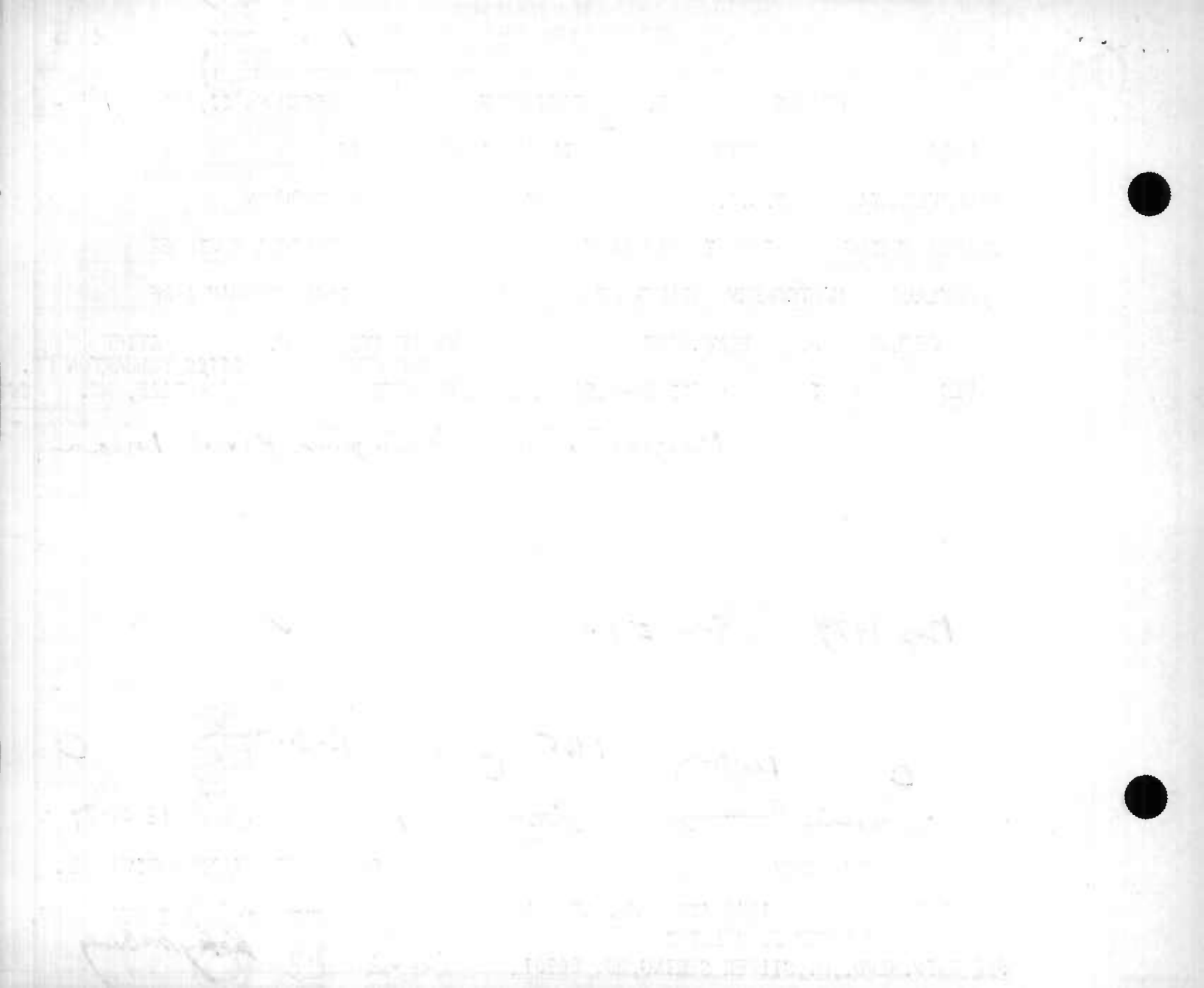
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 7 9 3 1 2 2 4				
1. DECEASED NAME (TYPE OR PRINT) FREDERICK H. Ebeling					2a. DATE OF DEATH MONTH DAY YEAR 12 29 79				
3 SEX MALE					4 RACE CAUCASIAN				
5 DATE OF BIRTH MONTH DAY YEAR 3 25 97					6 AGE (IN YEARS LAST BIRTHDAY) 82				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK					7b CITIZEN OF WHAT COUNTRY? USA				
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD				
10 CITY OR TOWN OF DEATH BETHESDA					11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETHESDA HEALTH CARE CTR.				
12a USUAL OCCUPATION (12b IF WORK FOR MFG. OF WORKING LIFE) PROOF READER					12b KIND OF BUSINESS OR INDUSTRY PRINTING				
13a STATE MARYLAND					13b COUNTY MONT.				
13c CITY OR TOWN SILVER SPRING					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14 FATHER'S NAME FIRST MIDDLE LAST HENRY EBELING					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHRINE BAUM				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b SOCIAL SECURITY NO WWW 096-10-3119				
17 INFORMANT ADDRESS SAME AS					17b ELIZABETH L.S. EBELING - ITEMS 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) myocardial infarction									
410- } DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) (this hospital) attended the deceased from 12-13, 19 79, to 12-29, 19 79, that (we) last saw the deceased alive on 12-13, 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did (did not) view the body after death.)									
22b SIGNATURE James Brodsky MD					22c DATE SIGNED 12-29-79				
22d PHYSICIAN'S NAME (TYPE OR PRINT) James Brodsky					22e ADDRESS 4701 Willard Ave Chevy Chase Md 20015				
23a BURIAL, CREMATION, REMOVAL BURIAL					23b DATE JAN. 3-1980				
23c NAME OF CEMETERY OR CREMATORY ARLINGTON NATL					23d LOCATION CITY OR TOWN COUNTY STATE FT. MYER - VIRGINIA				
24 FUNERAL DIRECTOR NAME W.W. CHAMBERS Co.					25a DATE REC'D. BY REGISTRAR JAN 4 1980				
25b REGISTRAR'S SIGNATURE W.W. CHAMBERS Co. MARYLAND									

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 2 2 5 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) GEORGE E. ECKENDORF				DECEMBER 21, 1979			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 28, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1902 WINDHAM LANE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANICAL ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE E. ECKENDORF				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGUERITE N. STIEF			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW I		17. INFORMANT DAUGHTER		ADDRESS 13122 DUMBARTON DR. ROCKVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Fibrous Histiocytoma of Bone 1719							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION May 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED See #18		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1965 , 19 1 , to 12-21-79 , 19 1 , that (I) (we) last saw the deceased alive on 12-21-79 , 19 1 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Morris Perry DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-21-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORRIS PERRY				22e. ADDRESS 11602 GEORGIA AVENUE, SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/26/79		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE Robert A. Kelly	



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 2 2 6

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Georgia M. Eicher			2a. DATE OF DEATH MONTH DAY YEAR December 8, 1979			2b. HOUR 1:25 ^A PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 13, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Rockville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 199 Rollins Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST William Maynard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minna Townley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 44 6147		17. INFORMANT ADDRESS 9503 Page Avenue Maynard Eicher Bethesda, Md. 20014					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>old age</u> 4140 DUE TO OR AS A CONSEQUENCE OF <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u> DUE TO OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yr</u> <u>yr</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>UTI, EBS, ASHD (w. Fb) P.A.</u>									
19a. DATE OF OPERATION 1			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Rd			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8 Feb 11, 19 70 to Dec 8, 19 79			
22a. I certify that (i) (the hospital) attended the deceased from <u>12-31-79</u> to <u>12-8-79</u> , that (i) (the deceased) was the deceased alive on <u>12-31-79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) did not view the body after death.									
22b. SIGNATURE <u>John S. Saia</u> DEGREE						22c. DATE SIGNED 12/10/79		22d. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Saia, M.D.						22f. ADDRESS 809 Viers Mill Rd. Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/11/79		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND						25a. DATE REC'D. BY REGISTRAR DEC 12 1979			
						25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>			

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79	3	1	2	2	7		
1. DECEASED NAME FIRST MIDDLE LAST EARL Hector EIMER										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR Dec 22 19 79						2b. HOUR MIN SEC 7:15 P M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Jan 6 19 82		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 82 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Dec 22 19 79		2d. HOUR MIN SEC 7:15 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Sil. Spg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2313 Hermitage Ave				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GLASS TECHNICIAN				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN Sil. Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2313 Hermitage Ave									
14. FATHER'S NAME FIRST MIDDLE LAST CONRAD EIMER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAIDIE GOOSEBACK				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES WW I				16b. SOCIAL SECURITY NO. 578-58-7952		17. INFORMANT LESTER W. MYERS		ADDRESS 2201 HERMITAGE AVE SILVER SPRING, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE John S. Rogers, M.D.										TITLE (SPECIFY) M.D.				MEDICAL EXAMINER		DATE SIGNED Dec 22 19 79	
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS										ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/26/79		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.							
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE Anthony M. Brady					

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal of the body. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, also the Medical Examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 2 8

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA S. Eisenberg			2a. DATE OF DEATH MONTH DAY YEAR 12-4-79			2b. HOUR 5:05 AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 19, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.		
13a. STATE MARYLAND			13b. COUNTY Montgomery		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2525 GLENALLAN AVENUE, APT. 103	
14. FATHER'S NAME FIRST MIDDLE LAST AARON SHERMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER ZARITSKY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-44-4125		17. INFORMANT ADDRESS DR. NORMAN A. EISENBERG 1208 HARDING LANE, SILVER SPRING, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular Fibrillation 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Fever, anemia, hepatosplenomegaly, lymphadenopathy - etiology undetermined										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1962 to 4 December 1979, that (I) (we) last saw the deceased alive on 4 DECEMBER 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jas. Gelfer, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-4-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASIN GELFER, M.D.			22e. ADDRESS 830 CAMERON STREET SILVER SPRING, MD. 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/6/1979		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VIRGINIA			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.										
25a. DATE REC'D. BY REGISTRAR 12/11/79 25b. REGISTRAR'S SIGNATURE										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 2 2 9		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT)		FIRST MARY MIDDLE WOODSON LAST ELLIS		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
MARY		W ELLIS		Dec. 15 79		9 A M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
Female		WHITE		7 4 02		77 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Rockville		Collingswood Nursing Center		Homemaker		Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
		Md.		Montgomery		Chevy Chase		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		13a STREET ADDRESS					
FIRST MIDDLE LAST		FIRST MIDDLE LAST		4405 Elm St.					
Edward A Woodson		Roberta Browne							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
No		213-56-6508		Anne E. Albright, Dtr., 1861 Field Rd.		Charlottesville, Va.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19 IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1629		Carcinoma, lung, metastatic		1 1/2 yrs					
DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION		21g CITY OR TOWN COUNTY STATE			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET					
22a I certify that (1) (this hospital) attended the deceased from		10/22/79		to		12/15/79		that (1) (we) last	
saw the deceased alive on		12/13/79		and that in (my/our) opinion death occurred on the date and hour and from the causes stated					
above. (1) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		22c DATE SIGNED					
Thos G. Ward		MD		12/15/79					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f CITY OR TOWN		22g COUNTY STATE			
Thos G. WARD		6116 Rabinowitz, Bethesda, Md 20034		Arlington		Virginia			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION			
Burial		12/18/1979		Arlington National Cem.		Arlington, Virginia			
24 FUNERAL DIRECTOR		24a NAME		24b ADDRESS		24c DATE REC'D. BY REGISTRAR		24d REGISTRAR'S SIGNATURE	
Joseph Gawler's Sons Inc.		5130 Wisc Ave NW DC				DEC 19 1979		J. D. Co. (Signature)	



U. S. ...

Official ...

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 3 0

1- FOR
STATE
REGISTRAR

REG. NO.

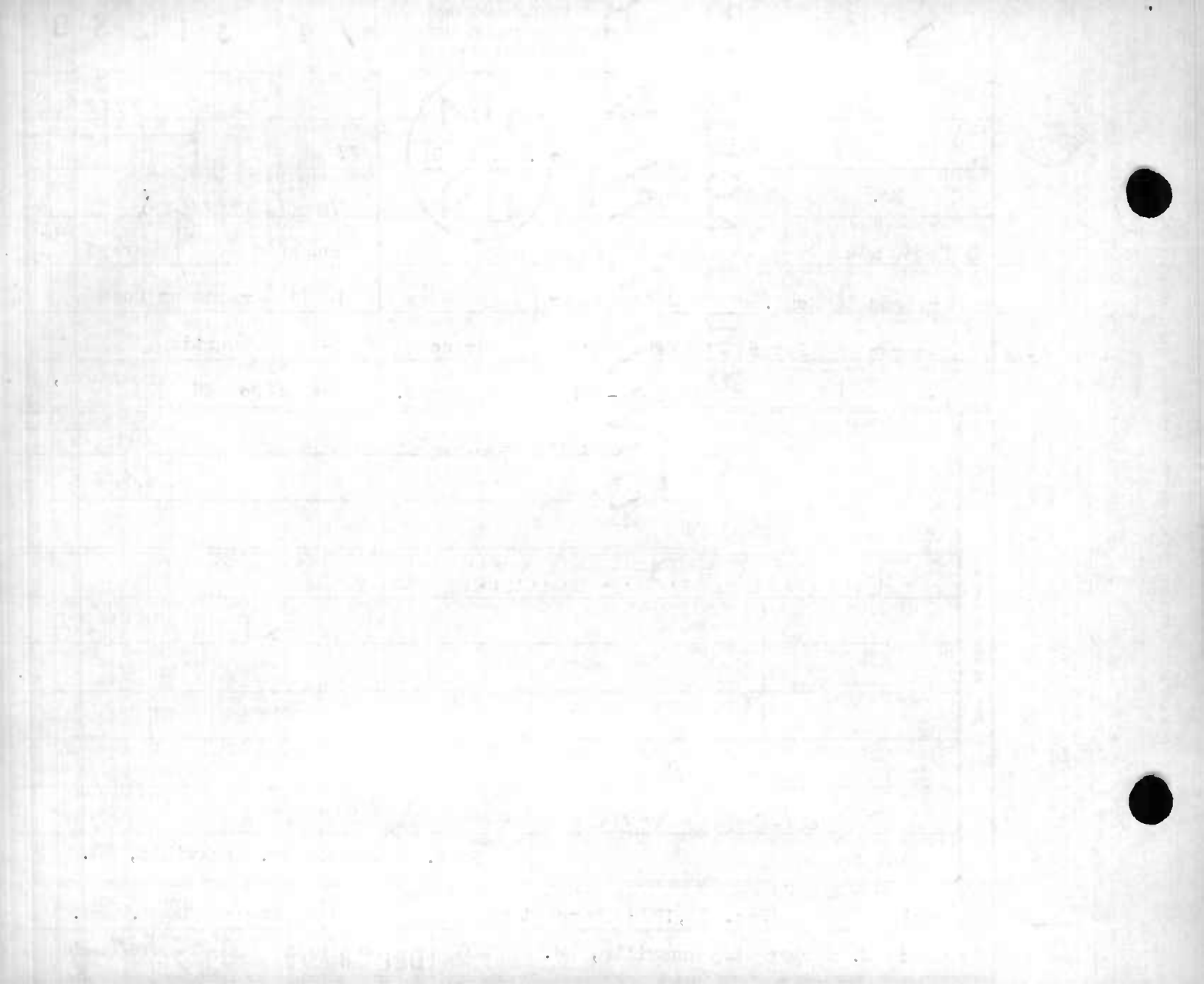
DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	DATE OF DEATH		MONTH	DAY	YEAR	HOUR
George Curtis Esworthy					12-19-79					8:40 PM
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	white	Feb. 6, 1902		77		MONTHS		DAYS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY OR COUNTY OF DEATH						
Md.	USA			Montgomery, MD.						
CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
\$ Bethesda		Suburban Hospital		Mechanic		Garage Auto				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
13a STATE		13b COUNTY		13c CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14011 Darnestown Road		
Maryland		Mont.		Gaithersburg						
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME						
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST
George		Peter		Esworthy		Grace		-		Curtis
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS				
no		220-32-7012 A		Dorothy H. Magers		POBox 88		Germantown, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Respiratory failure										24 hr
1629 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										6 wks
(b) Calvary										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Chronic obstructive pulmonary disease										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		HOUR A.M. MONTH DAY YEAR								
		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from 16 Dec 1979 to 19 Dec 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
Paul Noone				MD				19 Dec 79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
				50 W. Edmonston Dr. Rockville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE		
Burial		Dec. 22, 1979		Darnestown		Darnestown		Mont.		Md.
24 FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Francis H. Barber Laytonville, Md. 20760				DEC 20 1979		[Signature]				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 2 3 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Charles Louis EVEREST				2a. DATE OF DEATH MONTH DAY YEAR Dec. 29 1979		2b. HOUR 2:15 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 14 1928		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Cen.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN 13c. STREET ADDRESS New Jersey Cumberland Vineland				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 799 Cheltenham Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Everest				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ivy B. Hillbarn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1946 to 1967 220-22-1788		17. INFORMANT Camille Everest Lane, Clinton, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Squamous cell CA and Lung Metastasis 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) complicated by Bronchial Pnuemonia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 25 Nov 79 to 29 Dec 79 , that (we) lost saw the deceased alive on 29 Dec 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>George T. Gamblin</i>				DEGREE MD		22c. DATE SIGNED Dec. 31 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George T. Gamblin, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/ 5/ 80		23c. NAME OF CEMETERY OR CREMATORY Siloan Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Vineland New Jersey	
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Home, Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR JAN 7 1980		25b. REGISTRAR'S SIGNATURE <i>John A. Brady</i>	



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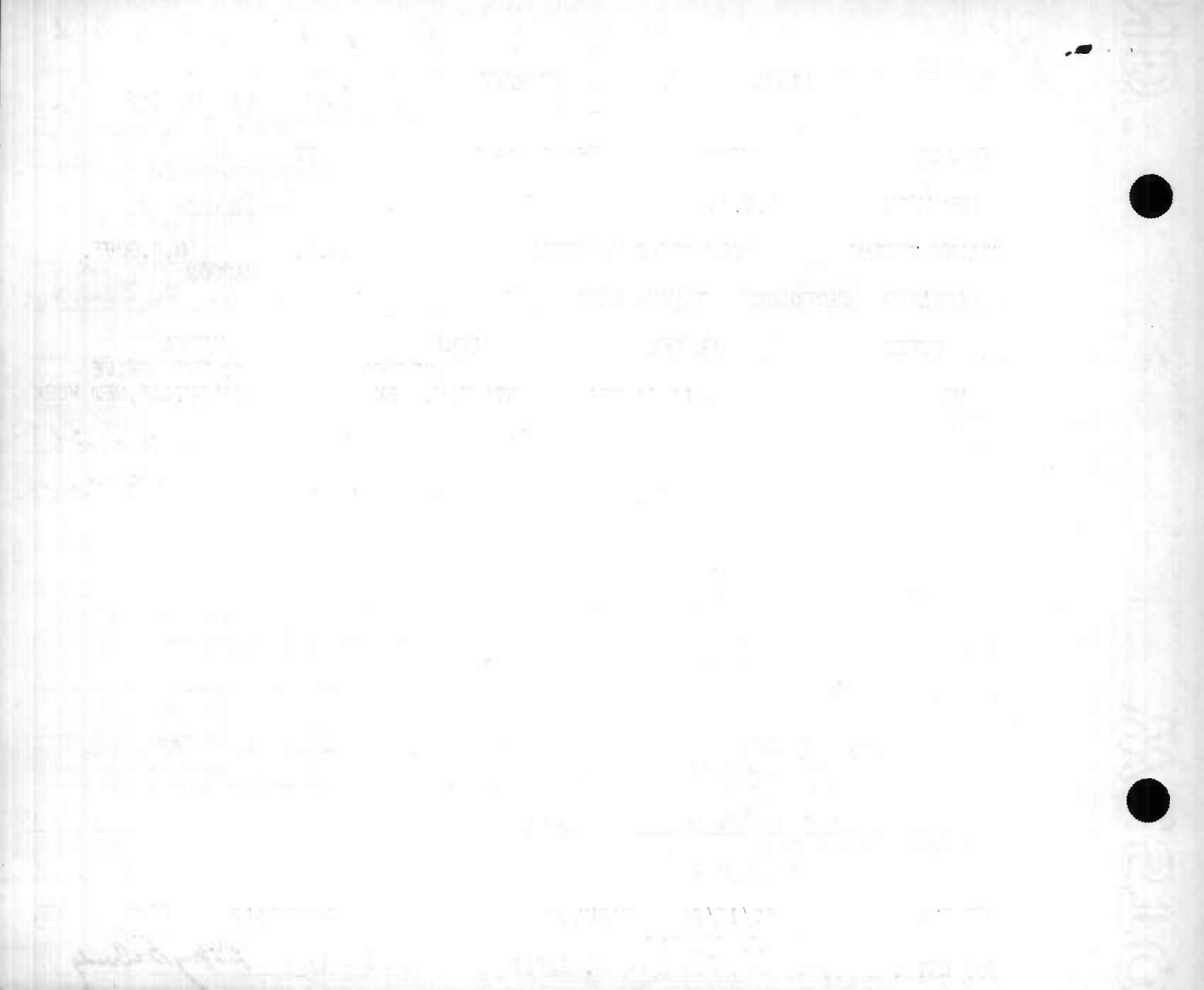
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 2 3 2			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Linda</u> <u>EVERITT</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>Dec 13 19 79</u>		2b. HOUR <u>3 40 AM</u>	
3 SEX <u>FEMALE</u>		4 RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>FEB 3, 1907</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>72</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>NEW YORK</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.	
10 CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSPITAL</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>G.A.O.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	
13a. STATE <u>MARYLAND</u>				13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>TAKOMA PARK</u>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>PETER</u> <u>MENGEL</u>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>LENA</u> <u>HAPPEL</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>216-46-7566</u>		17 INFORMANT <u>SISTER</u> <u>HILDA M. MIX</u>	
18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary</u>				18b. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchogenic Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
18c. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				18d. DUE TO, OR AS A CONSEQUENCE OF (c) _____		1 1/2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 7</u> 19 <u>79</u> to <u>Dec 13</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Dec 13</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) did not view the body after death.							
22b. SIGNATURE <u>Michael R. Dobadze</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Dec 13, 1979</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael R. Dobadze MD</u>				22e. ADDRESS <u>13975 Connecticut Ave Silver Spring MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>12/17/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>ROCKVILLE MONT ME.</u>	
24 FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> <u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 17 1979</u>		25b. REGISTRAR'S SIGNATURE <u>History McBrady</u>	



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO. 7 9 3 1 2 3 3					
1. DECEASED NAME (TYPE OR PRINT) Edward D. FALKENBURG				2a. DATE OF DEATH MONTH DAY YEAR Dec. 29 1979				2b. HOUR 1244 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr. 11 1918		6. AGE (IN YEARS LAST BIRTHDAY) 61		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FLORIDA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Naval Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Air Force		12b. KIND OF BUSINESS OR INDUSTRY armed services	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VA.				13b. COUNTY Fairfax		13c. CITY OR TOWN Annandale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN JAY FALKENBURG				15. MOTHER'S MAIDEN NAME MARY Hewitt WOOTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Vietnam		17. INFORMANT ADDRESS 4704 Eddystone Mrs. Olga Falkenburg Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Brain stem compression and destruction (c) Metastatic cancer to the brain								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 2 months 2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Meningitis due to Staphylococcus aureus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 12 Nov 1979, to 29 Dec 1979, that (I) (we) lost saw the deceased alive on 29 Dec 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE R. Lindsay Hilly, Jr.						22b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 29 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Lindsay Hilly, Jr.				22e. ADDRESS Nat'l Naval Med. Ctre., Beth., Md.					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Jan. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Pearson's Funeral Home				24b. ADDRESS 472 N. Wash. St. FC		25a. DATE RECEIVED BY REGISTRAR JAN 4 1980			
25b. REGISTRAR'S SIGNATURE [Signature]									



Edwards nm TANKENBURG Dec. 22 1975 1244P

Male Caucasian Apr. 11 1916 61

U.S.A. Montgomery

Edwards Naval Hospital U.S. Air Force

VA. Fairfax 4704 Edgystone Street

4704 Edgystone

267-16-2281M. 1671 Tankenburg Street

Montgomery 20 mi.

12 mi. from Washington and Arlington

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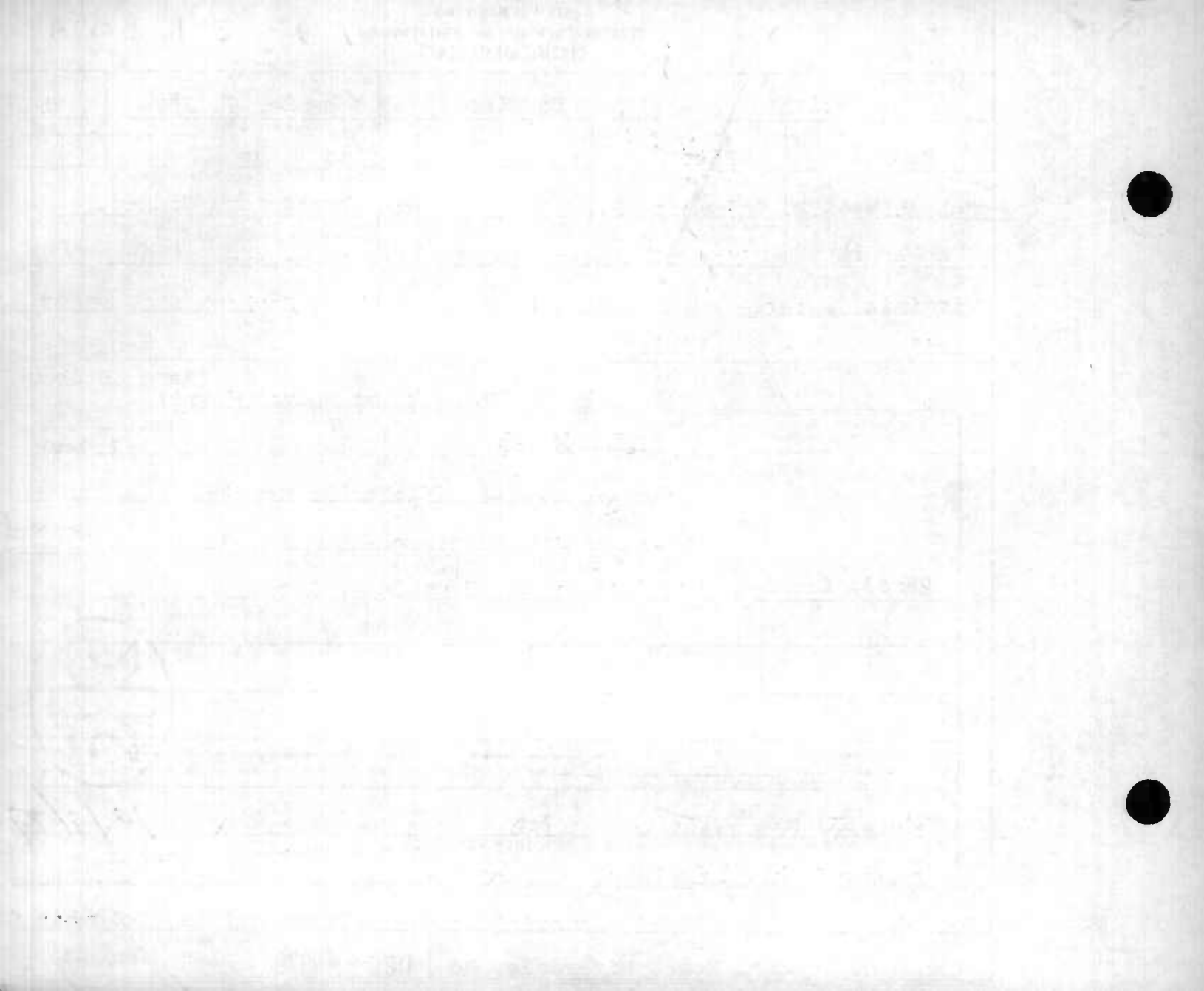
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					7 9 3 1 2 3 4				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR				
Tatiana Josefi Fandino					December 7, 1979				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		MONTH DAY YEAR		27 YRS		4:25 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Colombia, S.A.		Colombia, S.A.				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Clinical Center, (NIH)		Secretary		Bank			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
Virginia Fairfax Annandale					7476 Jayhawk St. 22003				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Kiril - Pikieris					Ines - DeCastro				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS (same as above)		
No					N/A		231-82-7387 Mrs. Himera Cuevas (aunt)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Septic Shock</u>									4 days
2050 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fungal sepsis / Klebsella Sepsis</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Promyelocytic leukemia</u>									16 Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Renal, Cardiac, Respiratory and Hepatic Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>Nov. 26,</u> 19 <u>79</u> , to <u>Dec. 7,</u> 19 <u>79</u> , that <u>x</u> (we) last saw the deceased alive on <u>Dec. 7,</u> 19 <u>79</u> , and that in <u>(x)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(x)</u> (we) (did) (not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>Robert M. Lester</u>				MD				<u>12/7/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
ROBERT M. LESTER				National Institutes of Health Clinical Center, Bethesda, Md, 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial		Dec/10/79		Memorial Gardens		Barranquilla, Colombia		SA	
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Chambers Funeral Home, Riverdale, Md						DEC 12 1979		<u>Robert M. Lester</u>	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) WILLIAM F. FEGLEY						2a. DATE OF DEATH MONTH 12 DAY 10 YEAR 1979		2b. HOUR 3 P.M.	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH 6 DAY 18 YEAR 1989		6 AGE (IN YEARS (LAST BIRTHDAY)) 90 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b KIND OF BUSINESS OR INDUSTRY Railroad	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Chevy Chase		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 3 E. Lenox Street	
14 FATHER'S NAME FIRST Richard MIDDLE E. LAST Fegley				15 MOTHER'S MAIDEN NAME FIRST Emma MIDDLE V. LAST Hartman					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 712-14-0022		17 INFORMANT ADDRESS Harry D. Fegley, Same as 13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest 410- DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE MYOCARDIAL INFARCT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC HEART DIS. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 2 DAYS YEARS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (this hospital) attended the deceased from 12/10 19 79 , to 12/10 19 79 , that (I) (we) last saw the deceased alive on 12/10 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b SIGNATURE Daniel Rosenthal				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12/10/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM				22e ADDRESS 10400 CONNECTICUT AV KENSINGTON, MD 20795					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Dec. 13, 1979		23c NAME OF CEMETERY OR CREMATORY George Washington Memorial Cemetery		23d LOCATION CITY OR TOWN Paramus COUNTY New Jersey STATE New Jersey			
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY				24b ADDRESS HOMES, P.A., BETHESDA, MARYLAND		25a DATE REC'D. BY REGISTRAR DEC 14 1979		25b REGISTRAR'S SIGNATURE [Signature]	

21532

U.S.A.

Tennessee

2 E. Lanox Street

Memphis Tennessee

Richard

LeRoy

John

711-14-0012 (Part 1) LeRoy, Sam as 176

60.12.1970

ROBERT J. ...

HOMES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
7 9 3 1 2 3 6									
1. FOR STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alex (NMN) Filipovich						2a. DATE OF DEATH MONTH DAY YEAR December 8, 1979		2b. HOUR 12:55^A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 56		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Govt. Emp.		12b. KIND OF BUSINESS OR INDUSTRY Nat. Bur. of Standards	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Filipovich						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W W II		17. INFORMANT Mrs. Lois Filipovich		ADDRESS 312-18-7952			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 7100 IMMEDIATE CAUSE (a) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Systemic Lupus Erythematosus DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) this hospital attended the deceased from 27 November, 79 to 8 December, 19 79 XX saw the deceased alive on 8 December, 19 79 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) did not view the body after death.									
22b. SIGNATURE B. R. Miller		DEGREE		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Byron D. McKeen		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/11/79		23c. NAME OF CEMETERY OR CREMATORY Woodbine Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Harrisonburg, Va.			
24. FUNERAL DIRECTOR NAME Lindsey Funeral Homes, Inc.		ADDRESS Harrisonburg, Va.		25a. DATE RECEIVED BY REGISTRAR DEC 14 1979		25b. REGISTRAR'S SIGNATURE <i>Harry McCreary</i>			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROSIE L. FINCHER		2a. DATE OF DEATH MONTH DAY YEAR December 15, 1979		2b. HOUR 3:47	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH March 7, 1895	
6. AGE (IN YEARS LAST BIRTHDAY) 84 yrs.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elevator Operator	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Maryland Montgomery Wheaton		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 3918 Lantern Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Harris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-48-9162A		17. INFORMANT ADDRESS Bertha Bell - Daughter SAA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumococcal Meningitis 3201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 79 , to 12/15 , 19 79 , that (I) (we) last saw the deceased alive on 12/15 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joel Schulman		DEGREE		22c. DATE SIGNED 12/18/1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schulman, M.D.		22e. ADDRESS 9410 Old Georgetown Road - Beth., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/20/1979		23c. NAME OF CEMETERY OR CREMATORY Local	
23d. LOCATION CITY OR TOWN COUNTY STATE Upperville, Virginia		24. FUNERAL DIRECTOR NAME ADDRESS W. Ernest Jarvis Co., Inc. 1432 U Street			
25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 3 1 2 3 8 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Virginia S. Fischer</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>DEC. 21 1979</u>			2b. HOUR M		
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>APRIL 25 1909</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>VIRGINIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.				
10. CITY OR TOWN OF DEATH <u>TAKOMA PARK</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>WASHINGTON ADVENTIST HOSP.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOMESICKER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u>			13b. COUNTY <u>MONT.</u>		13c. CITY OR TOWN <u>DERWOOD</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>6112 MUNCASTER MILL RD</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>William WEST</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Rosa Mundie</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO <u>230-10-8674</u>		17. INFORMANT ADDRESS <u>PAY A. FISCHER (Same as 13e.)</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular accident</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Rheumatoid arthritis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>Dec 7</u> , 19 <u>79</u> , to <u>Dec 21</u> , 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>Dec 20</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Herbert Baraf, MD</u>					DEGREE <u>MD</u>			22c. DATE SIGNED <u>12/21/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HERBERT BARAF, MD</u>					22e. ADDRESS <u>8750 Georgia Ave. Silver Spring, Md 20854</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>Dec 24, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Epiphany Church Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Odenton</u>			
24. FUNERAL DIRECTOR <u>Matthew Walters</u>					25a. DATE REC'D. BY REGISTRAR <u>DEC 27 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Robert McBrady</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 3 9

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			12 21 77			10:20 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White			Oct 8, 1887			92 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
England			USA						Montgomery MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Randolph Hills Nursing Home			Housewife			-----		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
D.C.			-----			Washington			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS					
FIRST MIDDLE LAST			FIRST MIDDLE LAST			6411 - 7th Street N.W.					
Eli Feldman			Alice (unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			100-26-0265A			Carol Munach; 12520 Rosebud Drive, Rockville Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c).									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>arteriosclerotic cardiovascular disease</i>									years		
4292 } DUE TO, OR AS A CONSEQUENCE OF <i>coronary disease</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			CITY OR TOWN COUNTY STATE					
AT WORK AT WORK											
22a. I certify that I (this hospital) attended the deceased from <i>5/25, 1975</i> , to <i>12/21, 1979</i> , that I (we) lost saw the deceased alive on <i>12/21, 1979</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) did not view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
<i>Barry N. Rosebaum, M.D.</i>						<i>12/21/79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
BARRY N. ROSEBAUM			3720 FARRAGUT AVE. KENSINGTON, MD. 20795								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
Burial			12-23-79			Sharon Gardens Cem.			Valhalla, New York		
24. FUNERAL DIRECTOR			NAME			ADDRESS			25a. DATE RECEIVED BY REGISTRAR		
Danzansky-Goldberg Chapels; 1170 Rockville Pike			Rockville, Md.						DEC 28 1979		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 1 2 4 0 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST EDGAR		MIDDLE WARREN		LAST FRASHER SR.		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 15, 1979		2b. HOUR 11:40 PM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV 04 38		6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S.A.F.		12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.			
13a. STATE D.C.		13b. COUNTY N/A		13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1582A EGLIN WAY, BOLLING AFB			
14. FATHER'S NAME FIRST MIDDLE LAST EDGAR PIERMONT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORIS ELAINE BEALMEAR		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO 1961-1979 525-82-9588		17. INFORMANT WIFE JOAN A. FRASHER		ADDRESS 1582A. EGLIN WAY BOLLING AFB, D.C. 20336	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DISSEMINATED ADENOCARCINOMA OF LUNG</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV. 20</u> , 19 <u>79</u> , to <u>DEC. 16</u> , 19 <u>79</u> , that (I) (we) lost the deceased alive on <u>DEC. 16</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <i>Mark D. Browning</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED DEC. 17, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK D. BROWNING, M.D.		22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC/19/79		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA					
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.		ADDRESS RIVERDALE, MD.		25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE <i>John A. ...</i>					

01212 2A

MC 15-11



... 10/10/1941 ...

Handwritten signature and the number 216108030



FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2d. HOUR	
Ernest		--		Frey				12		24		79		A		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	March 8, 1898		81 YRS.						Dec. 24		19		79		11 A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD	
Penna.		U.S.A.		WIDOWED		XX		Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda		4920 Westway Drive		Steam Fitter		Local 602											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4920 Westway Drive									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Harlan		--		Frey		Mary		--		Maury							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		578-05-9866		Francis W. Hulse		5320 Briley Pl., Beth., Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 411- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE		John S. Ball		M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED		Dec. 24, 1979							
EXAMINER'S NAME (TYPE OR PRINT)		John G. Ball		ADDRESS		Bethesda, Montgomery Co., Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		12/28/79		Ft. Lincoln Cemetery		Brentwood, Maryland											
24. FUNERAL DIRECTOR		5130 Wis. Ave., NW		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Joseph Gawler's Sons, Inc.		Washington, D.C. 20016		JAN 4 1980		[Signature]											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7931242			
1 - FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT) Jane Brickerd Friedrich.						2a DATE OF DEATH MONTH DAY YEAR 12-25-1979				2b HOUR 4:25 A.M.			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 1-19-26		6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7a IF UNDER 1 YEAR MONTHS DAYS		7b IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Pr, Geo. 13c CITY OR TOWN Glenn Dale						13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 6805 Glenn Dale Road					
14 FATHER'S NAME FIRST MIDDLE LAST Herbert S Brickerd						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Davy							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) n/a		17 INFORMANT 215 38 5446		17 ADDRESS William Friedrich Same as # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Adenocarcinoma</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 2 weeks 4 weeks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (a) (this hospital) attended the deceased from <u>12/16/79</u> , 19____, to <u>12/25</u> 19 <u>79</u> , that (b) (we) last saw the deceased alive on <u>12/16/79</u> , 19____, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated.													
22b. SIGNATURE <u>Thomas A. Bensinger</u>						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 25 Dec 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger						22e. ADDRESS 831 University Blvd E. Silver Spring MD 20903							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 28 DEC 79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Md.							
24 FUNERAL DIRECTOR Robert G. Beall NAME ADDRESS 9013 Annapolis Rd. Lanham, Md. 20801						25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE Hector McCreedy					



ST/PAI

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 79 31243							
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
Gilbert, Dave Fussell, Sr.		Dec 1, 1979				11:00 A.M.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
MALE	WHITE	DEC. 23, 1927		51		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
FLORIDA		U. S. A.				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. INDUSTRY	
TAKOMA PARK		WASHINGTON ADV. HOSPITAL				EXTERMINATOR		American Disinfection	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Prince Geo		College Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9122 BALTIMORE BL'VD.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
RAYFORD C. FUSSELL		EARNIE MAE TAYLOR							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
NO		254 38 5591		Gilbert D. Fussell Jr 606 Chillum Hgts Dr. Chillum, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) CVA									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		STREET		CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from 12/1/79 to 12/1/79, that (1) (we) lost saw the deceased alive on 12/1/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.									
22a. SIGNATURE		DEGREE				22c. DATE SIGNED			
David Cromwell		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12/1/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
David Cromwell, M.D.		831 University Bl'vd E. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		12/5/79		Ft. Lincoln Cem.		Brentwood P.G. Md.			
24. FUNERAL DIRECTOR		25. DATE RECEIVED BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Funeral Home P.A. Hyattsville, Maryland		DEC 4 1979							

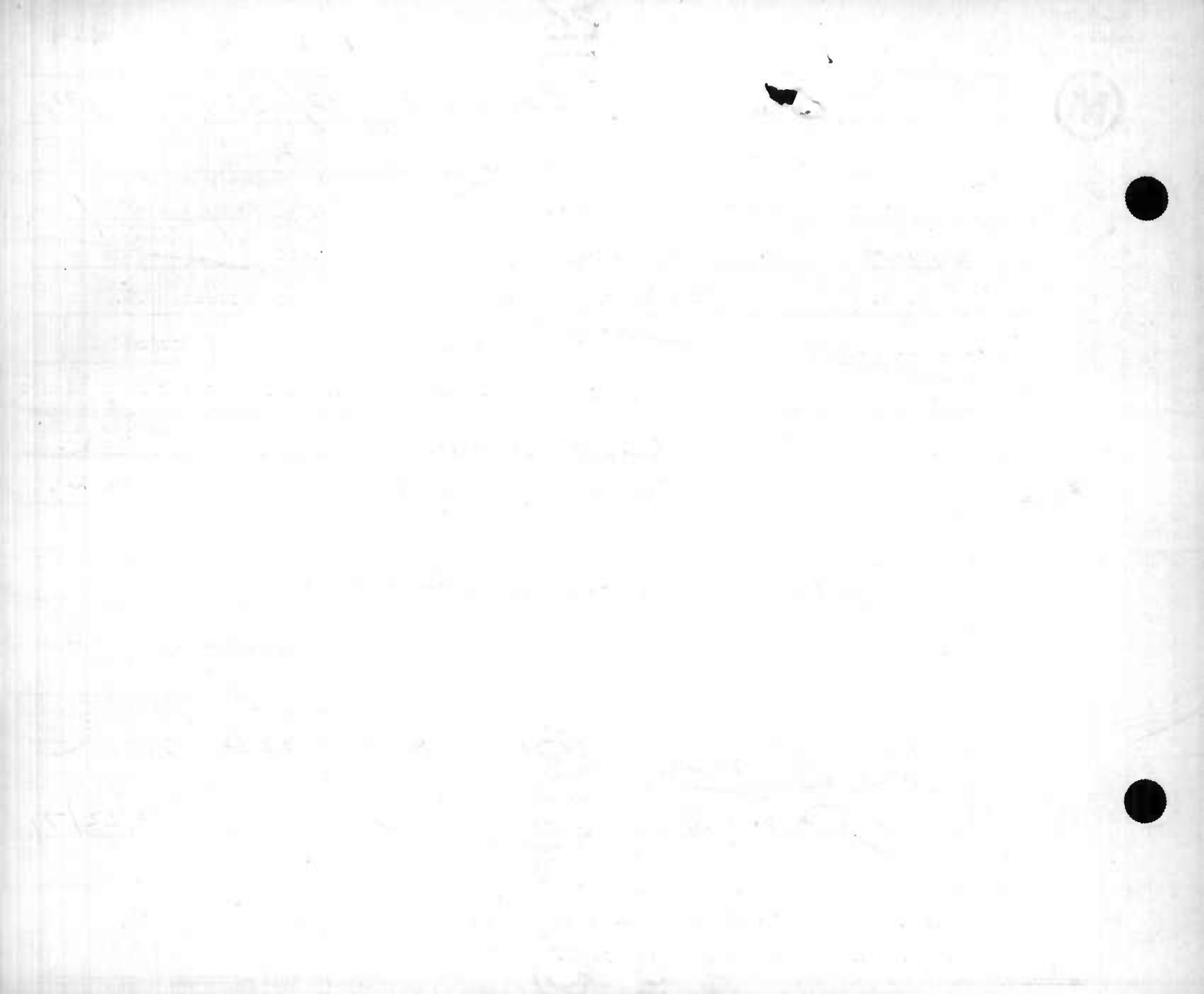


TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

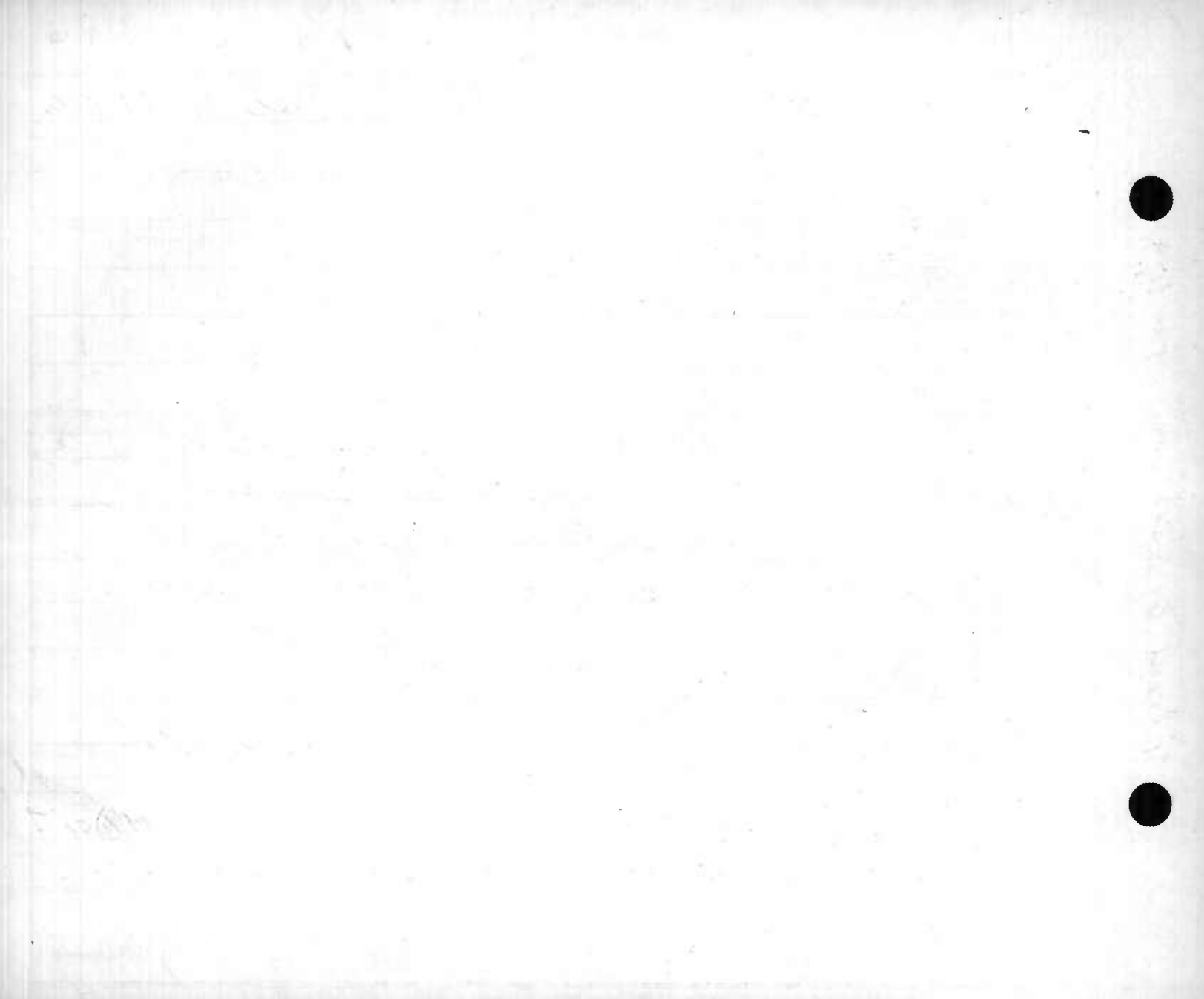
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 4 4			
FOR 1. STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Margaret L. Gardner								12/22/79					1:37 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS			
Female		Negro		3-26-17		62 YRS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
D. C.		USA				Montgomery County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital		Clerk		None							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
D. C.				Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5001 13th Street, N.E.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
James E. Hagner		Sarah Gordon											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		578-24-6532		Mrs. Catherine L. Best/daughter/same as 13e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a) Cerebral anoxia												20 hrs	
4275 DUE TO, OR AS A CONSEQUENCE OF												20 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) Cerebrovascular arrest													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Cirrhosis of the Liver, Diabetes mellitus													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION							
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2		CITY OR TOWN		COUNTY		STATE			
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET									
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 79, to Dec 22 19 79, that (I) (we) last saw the deceased alive on Dec 22 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED			
		MD		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		12/22/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		12-27-79		Lincoln Memorial		Suitland,				Md.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John T. Rhines Co., 3015 12th St., N.E., D.C.						JAN 4 1980		[Signature]					



cleared by Med-Exam. John Rogers
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 4 5	
1- FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) ELVA GARZONI				2a. DATE OF DEATH MONTH DAY YEAR Dec 11 '79				2b. HOUR 1000 AM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 30, 1902				6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Pennsylvania				13b. COUNTY Punxsutawney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS RD #5			
14. FATHER'S NAME FIRST MIDDLE LAST Grant Solada				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES) 163-12-5809		17. INFORMANT ADDRESS Richard Garzoni, RD #5, Punxsutawney, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute embolus of myocardial infarct 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Chronic coronary disease (c) Generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs 10-15 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Insulin dependent Diabetes Mellitus; arteriosclerosis											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10 Dec 1979 to 11 Dec 1979 , that (I) (we) last saw the deceased alive on 11 Dec 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Merton L. White MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Merton L. WHITE MD				22e. ADDRESS 9911 Georgia Ave Silver Spring MD 20902							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-14-79		23c. NAME OF CEMETERY OR CREMATORY Anita Roman Catholic		23d. LOCATION CITY OR TOWN COUNTY STATE Anita, Jefferson, Pennsylvania			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR DEC 14 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the files after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 4 6

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Ruth Virginia Gaynor			2a DATE OF DEATH MONTH DAY YEAR December 17, 1979			2b HOUR MIN. 12:01 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 21, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Damascus		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST William Wilkinson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise unknown			13e STREET ADDRESS 27500 Ridge Rd.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-64-7416		17 INFORMANT ADDRESS James W. Gaynor, Mt. Airy, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) cardiogenic heart failure months gave rise to immediate } DUE TO, OR AS A CONSEQUENCE OF cause (a), stating the } (c) chronic heart disease years underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) (this hospital) attended the deceased from 12/16 , 19 79 , to 12/17 , 19 79 , that (1) <input checked="" type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> saw the deceased alive on 12/17 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (2) <input type="checkbox"/> (3) <input type="checkbox"/> (4) <input type="checkbox"/> (5) <input type="checkbox"/> (6) <input type="checkbox"/> (7) <input type="checkbox"/> (8) <input type="checkbox"/> (9) <input type="checkbox"/> (10) <input type="checkbox"/> (11) <input type="checkbox"/> (12) <input type="checkbox"/> (13) <input type="checkbox"/> (14) <input type="checkbox"/> (15) <input type="checkbox"/> (16) <input type="checkbox"/> (17) <input type="checkbox"/> (18) <input type="checkbox"/> (19) <input type="checkbox"/> (20) <input type="checkbox"/> (21) <input type="checkbox"/> (22) <input 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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

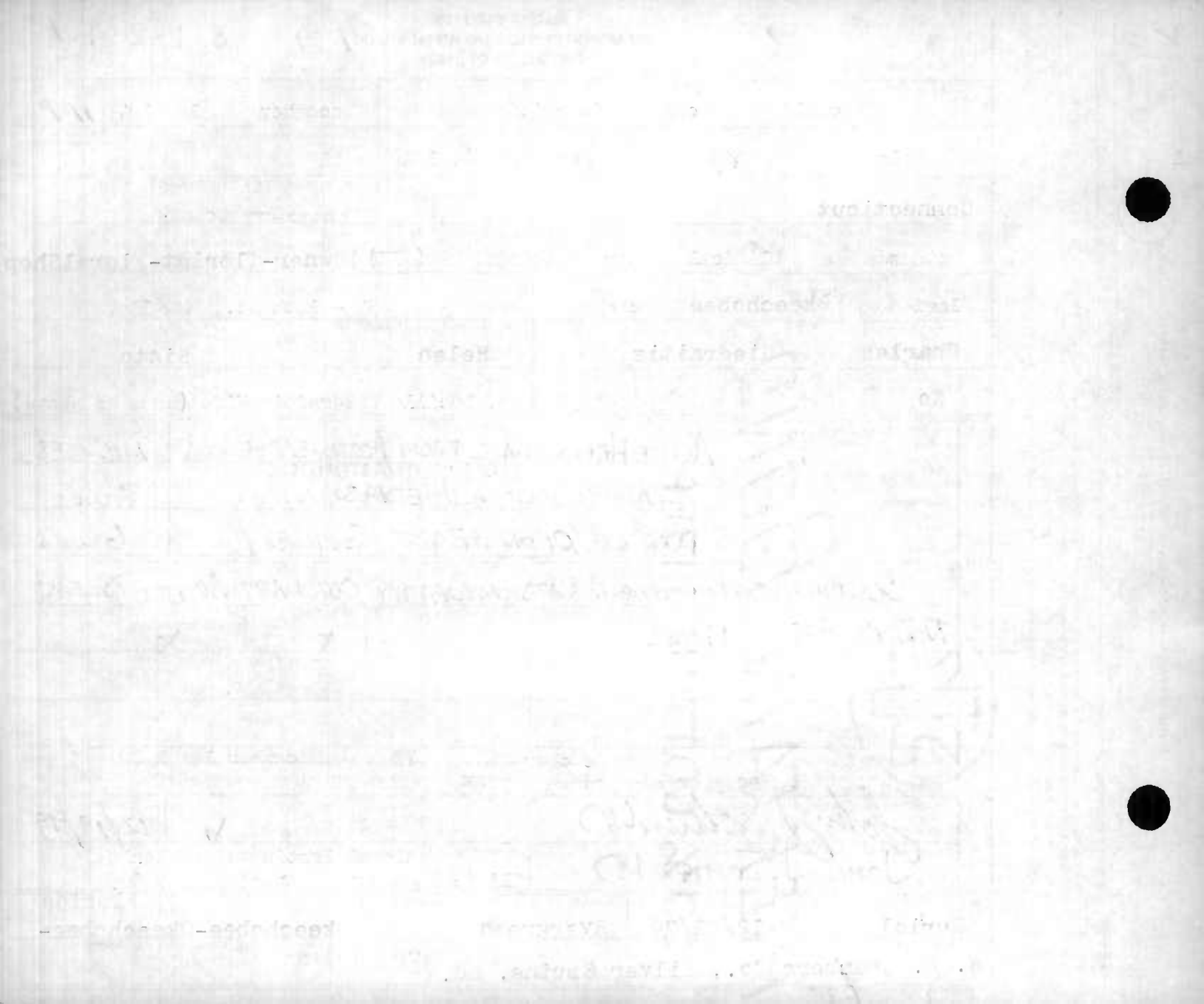
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald John Giedraitis			2a. DATE OF DEATH MONTH DAY YEAR December 18, 1979		2b. HOUR 11 P. M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 24, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, MD (NIH)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-florist	12b. KIND OF BUSINESS OR INDUSTRY FloralShop	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Florida			13c. CITY OR TOWN Okeechobee	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 57 - 10th St., BHR 33472
14. FATHER'S NAME FIRST MIDDLE LAST Charles Giedraitis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Sinto		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 049-26-8953	17. INFORMANT ADDRESS Mrs. Lucille Giedraitis, Wife (same as above)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0411 ACUTE HEMORRHAGE FROM AORTO-SAPHENOUS CRAFT ANASTOMOSIS DUE TO, OR AS A CONSEQUENCE OF (b) STAPHYLOCOCCAL MEDIASTINITIS DUE TO, OR AS A CONSEQUENCE OF (c) POST OP OPEN HEART SURGERY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 3 WKS 6 WKS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): OBSTRUCTIVE HYPERTROPHIC CARDIOMYOPATHY, CORONARY ARTERY DISEASE					
19a. DATE OF OPERATION Nov. 13, 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 11T.S.S.		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 28, 1979, to December 18, 1979, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 18, 1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. If <input type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE John J. Schier MD DEGREE				22c. DATE SIGNED 12/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. SCHIER, MD				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md 20205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/79	23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION CITY OR TOWN COUNTY STATE Okeechobee-Okeechobee-Florida
24. FUNERAL DIRECTOR NAME W. W. Chambers Co., Silver Spring, Md.		25a. DATE RECEIVED BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 3 1 2 4 8	
1. DECEASED NAME (TYPE OR PRINT) Edith Mary GILL			2a. DATE OF DEATH MONTH DAY YEAR December 20 1979			2b. HOUR 3:24P M					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 07 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Correspondent		12b. KIND OF BUSINESS OR INDUSTRY Red Cross			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George's 13c. CITY OR TOWN Hyattsville						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4704 40th Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST George Henry Morley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Goat				16. ADDRESS Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 42 3112B		17. INFORMANT Annetta Moore 5500 McKinley St. Bethesda,							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bronchopneumonia complicating</u> 485- DUE TO, OR AS A CONSEQUENCE OF <u>metastatic carcinoma of the breast</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 14</u> 19 <u>79</u> , to <u>Dec. 20</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Dec. 20</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or as amended) (did not) view the body after death.											
22b. SIGNATURE <i>R. Cushman</i>						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Dec. 21 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. CUSHMAN, M.D.						22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/24/79		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.			
24. FUNERAL DIRECTOR NAME Gasch's Funeral Home						ADDRESS Hyattsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

OFFICE OF THE CHIEF OF STAFF



UNITED STATES DEPARTMENT OF THE ARMY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 2 4 9		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Otto M. Glaser				2a. DATE OF DEATH MONTH DAY YEAR December 15, 1979		2b. HOUR 5:50am			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Precision Optics		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Clarksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 26400 Aiken Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Arnold Alex Glaser		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmine Auguste Ida Geiling							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-56-6089		17. INFORMANT ADDRESS H. Rosemarie Malone, Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asystole</u> <u>4/40</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.H.D. = A-F.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19____, to <u>12-15</u> <u>79</u> , that (I) have lost saw the deceased alive on <u>12-11-79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) were not (did not) view the body after death.									
22a. SIGNATURE <u>Jack Schumacher M.D.</u>				DEGREE M.D.		22c. DATE SIGNED <u>12-15-79</u>		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.				22e. ADDRESS 105 Russell Ave., Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 17, 1979		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.				25a. DATE RECD. BY REGISTRAR DEC 19 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		9 3 1 2 5 0 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 10:15 P M	
Mildred		Natalee		Glaze				12 25 79		10:15 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 29 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2609 East West Highway			
14. FATHER'S NAME FIRST MIDDLE LAST John Henderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lujan Lawson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578 12 3049		17. INFORMANT ADDRESS Leroy S. Glaze same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hepatic coma</u> 5712 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laennec's Cirrhosis</u> (c) <u>chronic alcoholism</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>79</u> , to <u>12/25</u> , 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>12/21</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Sidney J. Malawer</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/26/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Malawer		22e. ADDRESS 10215 Fernwood Road Bethesda, Md. 20034									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/79		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montgomery, Md.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE <u>Harvey McCreedy</u>							

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William Clements GLOYD			2a. DATE OF DEATH MONTH DAY YEAR Dec. 20, 1979			2b. HOUR 1:30A M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 20, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD					
10. CITY OR TOWN OF DEATH Damascus		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10511 Bethesda Church Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard		12b. KIND OF BUSINESS OR INDUSTRY Gov't			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10511 Bethesda Church Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Arthur Gloyd				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Augusta Clements							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 1		17. INFORMANT ADDRESS Nannie Cromwell Gloyd, Item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Interventricular cardiorenal disease</i> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 11/23, 1970, to 12/20, 1979, that (I) (the doctor) saw the deceased alive on 12/18, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.											
22b. SIGNATURE James P. Kerr, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec. 20, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James P. Kerr, M.D.						22e. ADDRESS 26618 Ridge Rd., Damascus, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 22, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Ros.		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg., Md.				
24. FUNERAL DIRECTOR NAME Olin L. Moleworth, Damascus, Md.						25a. DATE REC'D. BY REGISTRAR DEC 24 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 5 2 REG. NO.					
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST LEON		MIDDLE		LAST GOLDER		2a. DATE OF DEATH MONTH DAY YEAR 12 - 23 - 79				2b. HOUR 5 30 AM	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 6 - 15 - 97		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS				7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.									
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SBA Analyst (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY US Government			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 5480 Wisconsin Ave., #1025	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase											
14. FATHER'S NAME FIRST MIDDLE LAST Max ----- Golder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara ----- Blackman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 272-07-8462		17. INFORMANT ADDRESS Maryland Chevy Chase											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2898 UREMIA DUE TO, OR AS A CONSEQUENCE OF (b) Refractory Anemia DUE TO, OR AS A CONSEQUENCE OF (c) Bone Marrow failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 1 year 1 year.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Gastro-intestinal bleeding															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 12/6/1979 to 12/23/1979, that (I) (we) lost saw the deceased alive on 12/22/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death															
22b. SIGNATURE Harold I. Passes				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/23/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD I. PASSES MD				22e. ADDRESS 4425 Montgomery Ave Bethesda MD 20814											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-26-79		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Cdn.				23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia							
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.				25a. DATE REC'D. BY REGISTRAR DEC 28 1979				25b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 3 1 2 5 3			
FOR 1- STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISMAR GOLDSTEIN				2a. DATE OF DEATH MONTH DAY YEAR Dec. 20, 1979		2b. HOUR 11:04 AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 8, 1905		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4890 Battery Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Adolf Goldstein				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Natalie (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 577-20-5884A		17. ADDRESS Bethesda, Md. Johanna Goldstein; 4890 Battery Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 460RS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 77 12-20 79			
22a. I certify that (I) (this hospital) attended the deceased from 6-9 , 19 79 , to 12-20 , 19 79 , that (I) (we) lost saw the deceased alive on 12-11 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jerry A. Snow, M.D.				DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-20-1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JERRY A. SNOW, M.D.				22e. ADDRESS 4900 Mass. Ave., NW, Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-23-79		23c. NAME OF CEMETERY OR CREMATORY Wash. Heb. Cong. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike Rockville, Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE DEC 26 1979	



FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 79 31254			
1. DECEASED NAME (TYPE OR PRINT) Andres Gonzalez												2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 30 1979				2b. HOUR 1:18 M P											
3 SEX M		4 RACE M		5 DATE OF BIRTH MONTH DAY YEAR 4 04 10		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTH MIN		2c. DATE PRONOUNCED DEAD 12 30 1979				2d. HOUR 1:18 M P											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.															
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman				12b. KIND OF BUSINESS OR INDUSTRY Retired															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12606 Connecticut Ave																			
14. FATHER'S NAME FIRST MIDDLE LAST Francisco Gonzalez						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Soto																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) None				16b. SOCIAL SECURITY NO. 229 44 9512				17. INFORMANT ADDRESS Luisa Gonzalez (Wife) Same as above																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None																											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER 1919 Seminary Rd. S.S.Md.				DATE SIGNED Dec 31/1979															
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers				ADDRESS																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/3/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.																	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. ADDRESS 11800 N.H. Ave. S.S. Md.												25a. DATE REC'D. BY REGISTRAR JAN 4 1980				25b. REGISTRAR'S SIGNATURE Anthony McCready											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Ametta Head Goodman</i>			2a. DATE OF DEATH 12 - 17 - 79			2b. HOUR 8:00 M					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>5-1-84</i>		6. AGE (In years lost birthday) <i>45</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Tenn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>303 Bradley Ave</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Tenn</i>		13b. COUNTY <i>Robertson</i>		13c. CITY OR TOWN <i>Cedar Hill</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Rt 1</i>			
14. FATHER'S NAME First Middle Last <i>Hiram J. Head</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary M. Murphoy</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>413-76-7861</i>		17. INFORMANT Address <i>Brenda Fischer (daughter) Rockville, Md</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic cardiovascular disease 8 years</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 days.</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic congestive heart failure</i>											
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <i>NONE</i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>11-23, 1971</i> , to <i>12-17, 1979</i> , that (I) <i>(we)</i> lost saw the deceased alive on <i>12-11, 1979</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> (did) <i>(did not)</i> view the body after death.											
22b. SIGNATURE <i>Stephen C. Cromwell MD</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-17-79</i>				
22d. PHYSICIAN'S NAME (Type) <i>Stephen C. Cromwell MD</i>					22e. ADDRESS <i>615 W. Montgomery, Rockville, Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/20/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hopkinsville Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Hopkinsville, Kentucky</i>				
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home, Inc.</i>					25a. REC'D BY REGISTRAR <i>DEC 20 1979</i>			25b. <i>Signature</i>			

EXHIBIT 10

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31256

1. DECEASED NAME (TYPE OR PRINT) Ruth Ann Gray			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12/28 1979			2b. HOUR M			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 5, 1921	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 12/28 1979			2d. HOUR 11:00 A. M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 506 Bonifant Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 506 Bonifant Road	
14. FATHER'S NAME FIRST MIDDLE LAST Gerald G. Gray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite E. King					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) -----		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT (brother) John E. Gray		ADDRESS 34 A Ridge Road Greenbelt, Md. 20770			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>carcinoma of the bone.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None									
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) M.D. Deputy			DATE SIGNED 12/28/79			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-31-79		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.					25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE <i>Anthony J. Brady</i>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31257					
1. DECEASED NAME (TYPE OR PRINT) Patrick J Gregg										2a. DATE KNOWN OF DEATH ESTIMATED 12 13 79		2b. HOUR 6:19 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH SEPT DAY 7 YEAR 1909		6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7c. DATE PRONOUNCED DEAD 12-13 1979		7d. HOUR 6:19 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REAL ESTATE				12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19521 GALLATIN COURT							
14. FATHER'S NAME FIRST JOHN MIDDLE GREGG LAST ROSE						15. MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE DORRIS LAST DORRIS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-10-8819		17. INFORMANT MARY B. GREGG				ADDRESS SAME AS 13		WIFE WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute DUE TO, OR AS A CONSEQUENCE OF Conditions: if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE John B. Ball				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED Dec 13, 1979			
EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL				ADDRESS BETHESDA, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d. LOCATION CITY OR TOWN SILVER SPRING COUNTY MONT STATE MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS								25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE Anthony K. Brady					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901															

257121

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		7 9 3 1 2 5 8	
247 GUERNSEY GEORGE T. 20 1- ST. REGISTRAR NO HADI BAHAR 12/20/79 11002 KENILWORTH AVE NWYONE GUERNSEY, GEORGE T.		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) GUERNSEY, GEORGE T.		2a. DATE OF DEATH MONTH DAY YEAR 12 22 79	
3 SEX M		2b. HOUR 30	
4 RACE W		2c. MIN 12 A.M.	
5. DATE OF BIRTH MONTH DAY YEAR 07 17 09		6 AGE (IN YEARS LAST BIRTHDAY) 70	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Educator		12b. KIND OF BUSINESS OR INDUSTRY Labor Union	
13a. STATE Maryland		13b. COUNTY Montg.	
13c. CITY OR TOWN Garrett Pk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Austin Guernsey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice Seibert	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 327-16-9880	
17 INFORMANT Elsa Guernsey		ADDRESS Same as (13 A)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular accident</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerosis</u> (c) <u>Diabetes</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-20-79</u> to <u>12-22-79</u> , that (I) (we) lost saw the deceased alive on <u>12-21-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>H. Bahar</u>		22c. DATE SIGNED 12-22-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HADI BAHAR		22e. ADDRESS 8218 WISCONSIN AVE, BETH, MD 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 24, 1979	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Md	
24 FUNERAL DIRECTOR W. W. Chambers Co, 8655 Georgia Ave, Sil. Spg.		25a. DATE REC'D. BY REGISTRAR DEC 28 1979	
25b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>			

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 07-11-2001 BY 60322 UCBAW/STP/STP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

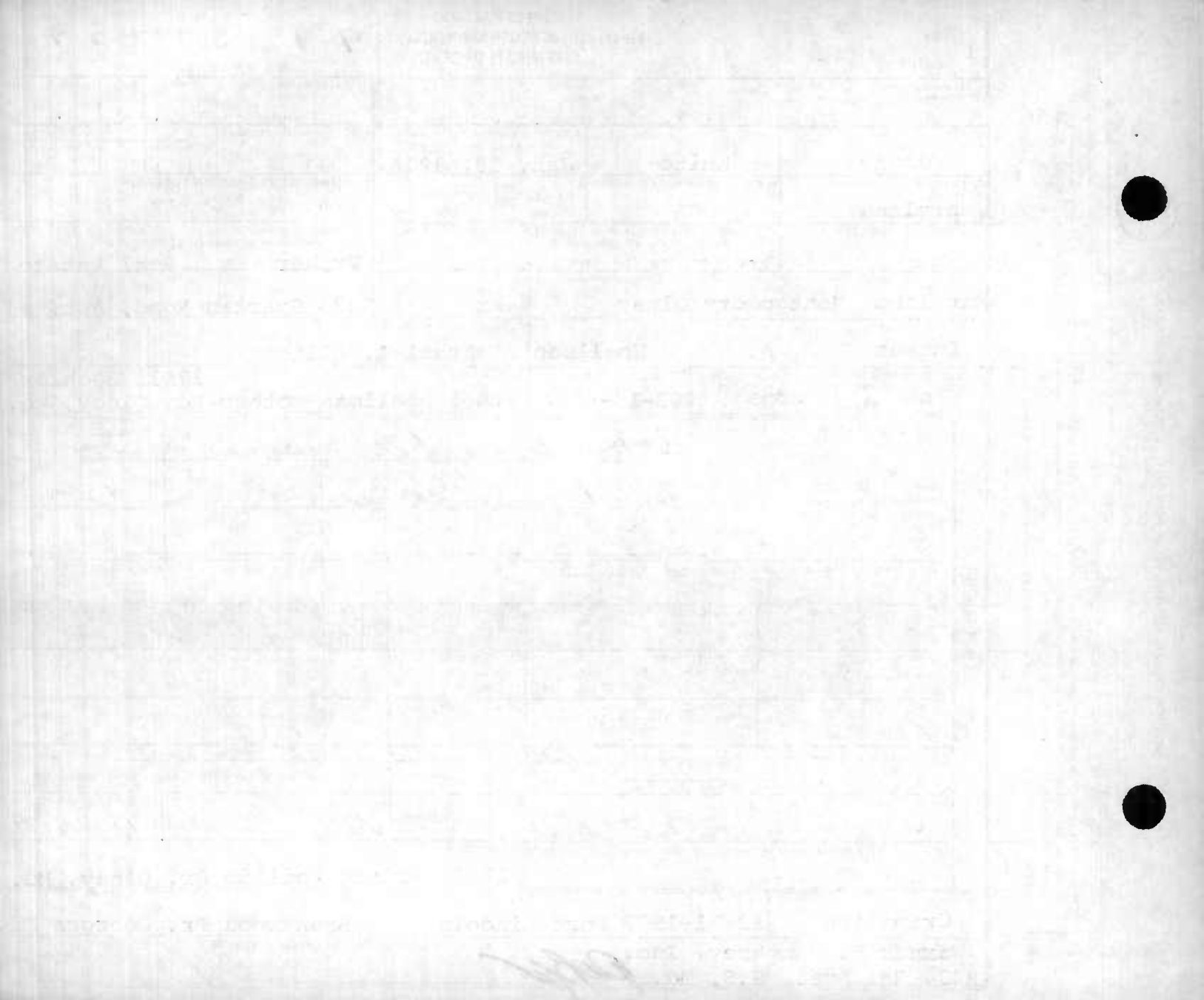
1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lois E. Hackner			2a. DATE OF DEATH MONTH DAY YEAR December 18, 1979		2b. HOUR 7:24a M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 20 1916		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 63	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Luther A. Hoellman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel A. Elliott-		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no none			
16b. SOCIAL SECURITY NO. 063-10-0194		17. INFORMANT ADDRESS 17811 Buehler Ethel Hoellman-mother-Rd. Olney, Md.					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Electrical lung and CNS metastasis 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo 4-5 mo.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August , 19 79 , to 18 Dec , 19 79 , that (I) (we) last saw the deceased alive on 17 Dec , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE Donald E. Dillon		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 18 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.		22e. ADDRESS 18111 Prince Phillip Dr. Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-21-1979		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.	
24. FUNERAL DIRECTOR Walner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE Anthony M. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

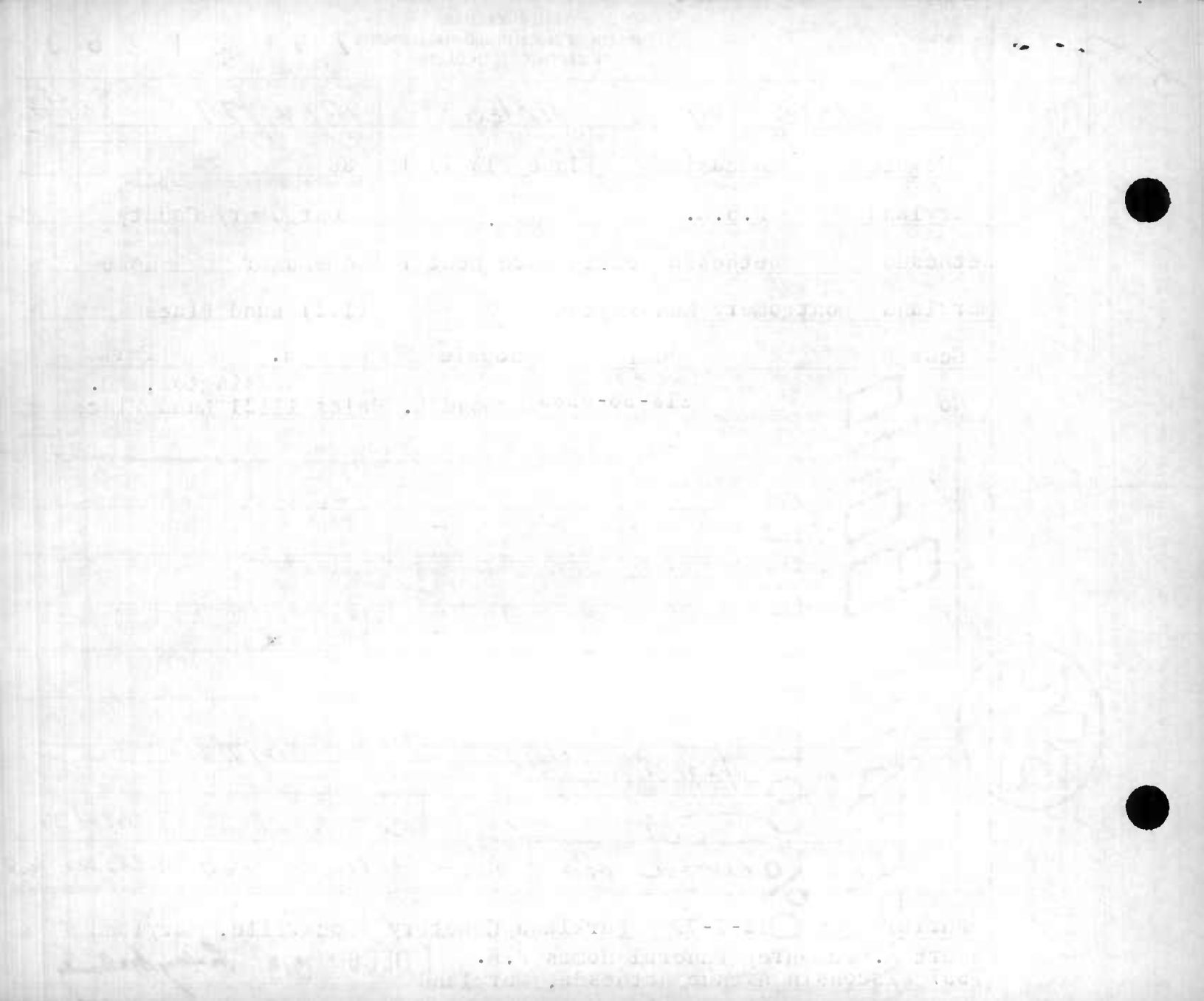


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 6 0			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) Elsie Pohl Hales					2a. DATE OF DEATH MONTH DAY YEAR 12/4/79				2b. HOUR 8:45 A.M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 13 1891		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Kensington					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11121 Lund Place						
14. FATHER'S NAME FIRST MIDDLE LAST George Pohl					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie B. Park								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-56-6563		17. INFORMANT ADDRESS Raymond L. Hales 11121 Lund Place Kensington, MD.									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal cerebral thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR —		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —							
22a. I certify that (I) (this hospital) attended the deceased from 6/5/79 , 19 — , to 12/4/79 , 19 — , that (I) (we) last saw the deceased alive on 11/27/79 , 19 — , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE 				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/4/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT A. PUMPHREY				22e. ADDRESS 7455 arlington road Bethesda MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-79		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland							
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes P.A.				25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE 							
25c. ADDRESS 7557 Wisconsin Avenue Bethesda, Maryland													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31261

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		ESTI-MATED	MONTH	DAY	YEAR	2b. HOUR
Susan C. Halsey					Dec 29 1979						A M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR
female	white	Dec. 2 1902		77 YRS.	MONTHS DAYS HOURS MIN.				Dec 31 1979		3 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA				Montgomery MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		3314 Chiswick Court				Housewife		own home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3314 Chiswick Court			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
William E. Caveny		Alice J. Fetter									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (brother) ADDRESS							
		180-14-6440		8709 Navaho St. William E. Caveny, Jr. Phila. Pa.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease.</u> 4039 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
				STREET		CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE					
John G. Ball		M.D. Deputy				MEDICAL EXAMINER				Jan 1, 1980	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
John G. Ball, DME		Bethesda, Montgomery Co. Md.									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		25a. DATE REC'D. BY REGISTRAR			
Cremation		Jan. 2-80		Metropolitan Crematory		Alexandria Fairfax Md.		JAN 4 1980			
24. FUNERAL DIRECTOR		25b. REGISTRAR'S SIGNATURE									
Warner E. Pumphrey, Inc.		8434 Ga. Ave., S.S. Md.				R. J. Brady					

23a. BURIAL, CREMATION, REMOVAL

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

Warner E. Pumphrey, Inc.

8434 Ga. Ave., S.S. Md.

JAN 4 1980

R. J. Brady

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 6 2

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2r. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	P
James		J		Harlee	12-26-79				3:15	M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male	Black	Nov. 9, 1938		41	MONTHS		DAYS		HOURS	
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
West Va.	U.S.A.			Montgomery MD.						
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda	Urban Hospital									
13r. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Montg.	Rockville		YES <input type="checkbox"/> NO <input type="checkbox"/>		303-A Dawson Avenue			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST James J. Harlee, Sr.				FIRST MIDDLE LAST Zeolia Bishop						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS						
No		236-60-4510		Warren Harlee (Brother) same as #13						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration</u> 2377 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>Neurofibromatosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs - 10 yrs -
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Steroid dependence, Platelet deficiency, decubitus ulcers, septicemia</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
12/8/79		Scrotal abscess			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21r. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/22/79</u> , 19 <u>79</u> , to <u>12/26</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/26</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE				DEGREE				22c. DATE SIGNED		
<u>Sidney S. Cohen</u>				MD				12/27/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22r. ADDRESS						
Sidney S. Cohen				121 Congressional Lane, Rockville						
23r. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		12-31-79		Parklawn Memorial Park		Rockville, Montg. Md.				
24 FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
George R. Snowden 246 N. Washington Street Rockville, Md. 20850				JAN 2 1980		<u>[Signature]</u>				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



James 4 13-26-75 3:12

Wife
Husband
W. A.
Indemnity

Methodist
Episcopal

Mr. Mont. Rockville
303-7 Dawson Avenue

James J. Taylor, Sr.
Taylor's Station

236-60-6510
James Taylor (Brother) same as 413

James J. Taylor, Sr.
Rockville, Md. 20850
236-60-6510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.				7 9 3 1 2 6 3					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
William Leonard		HARRELL						12-21-79		1 45 P M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		Caucasian		Aug. 28, 1900		79 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
70 North Carolina		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
70 Bethesda		Suburban Hosp						Clerk		WSSC	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
35 Maryland		Montgomery		Bethesda				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4879 Battery Lane #21	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
150 William Leonard Harrell		Mary Louise Salsbury									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
no		577-26-4223		Alice Buxbaum		7819 Custer Road		Bethesda, Maryland			
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sepsis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs</u>	
0389 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Failure</u>										Days	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> , 19 <u>79</u> , to <u>12/21</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Joel Schulman</u> DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/21/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joel Schulman</u>		22e. ADDRESS <u>9410 Old George Run Rd</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>12/22/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crem.</u>		23d. LOCATION CITY OR TOWN <u>Alexandria, Virginia</u> COUNTY STATE					
24. FUNERAL DIRECTOR NAME <u>Robert A. Pumpley</u>		24b. ADDRESS <u>Homes, P.A. Bethesda, Maryland</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 27 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 6 4 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ETHEL HAYES HARRIS						2a. DATE OF DEATH MONTH DAY YEAR 12-20-79			2b. HOUR 1022 P		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11-30-06		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? Amer.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Milwash. Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) house wife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Mont. 13c. CITY OR TOWN S.S.						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9039 Sligo Creek Parkway			
14. FATHER'S NAME FIRST MIDDLE LAST UNK Hayes						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None				16b. SOCIAL SECURITY NO. 579 38 9926		17. INFORMANT ADDRESS Paul Harris (Son) Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 5770 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) PLEURAL EFFUSION 2° PANCREATITIS DUE TO, OR AS A CONSEQUENCE OF (c) SHOCK 2° PANCREATITIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) PANCREATITIS, INFARCTED BOWEL, POSSIBLE SEPSIS											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 19 to 20 DEC 19 79 , that (1) (we) last saw the deceased alive on 20 DEC 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) not view the body after death.											
22b. SIGNATURE William Gerling						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Gerling						22e. ADDRESS Washington Adventist Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/24/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800						ADDRESS N.H.Ave.S.S.Md.		25a. DATE REG. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE John M. Brady	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 6 5
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Joseph Harrison					2a. DATE OF DEATH MONTH DAY YEAR 12 10 79			2b. HOUR 5:40 AM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 9- 5- 1928		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George Co, Md. Mont MD.				
10. CITY OR TOWN OF DEATH P.G. County		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Advenist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY P.G.		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Harrison					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Wood					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 213-24-3088		17. INFORMANT ADDRESS Catherine Harrison Same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombocytopenia DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) Lymphoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
21g. I certify that (I) (this hospital) attended the deceased from 10 31 19 79 to 10 Dec 19 79 , that (I) (we) lost sight of the deceased alive on 9 Dec 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (we) (did) (did not) view the body after death.										
22a. SIGNATURE Thomas A. Bensagen MD						22b. ADDRESS 831 Univ Blvd B. Sil/Sig MD 20903		22c. DATE SIGNED 10 Dec 79		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/13/79		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md			
24. FUNERAL DIRECTOR NAME Johnson & Jenkins Inc						25. DATE REC'D. BY REGISTRAR DEC 19 1979		25b. REGISTRAR'S SIGNATURE [Signature]		



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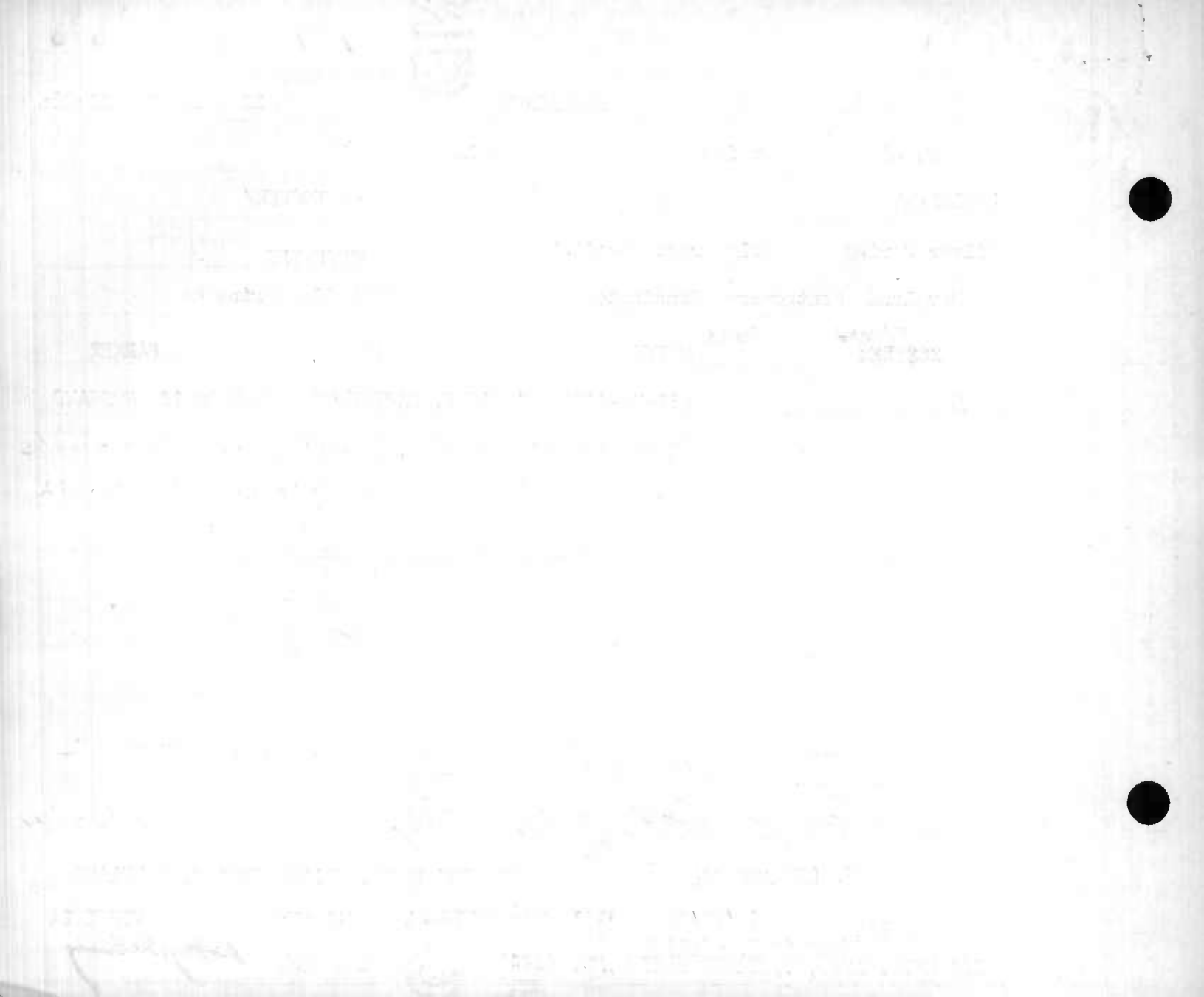
1950-1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 79 31266							
1. DECEASED NAME (TYPE OR PRINT) ALICE W HARTSTACK					2a. DATE OF DEATH MONTH DAY YEAR 12 - 23 - 79			2b. HOUR 11:28a	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 - 28 - 12		6. AGE (IN YEARS LAST BIRTHDAY) 67		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOUISIANA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9637 Old Spring Rd	
14. FATHER'S NAME FIRST Edward MIDDLE James LAST WHITE				15. MOTHER'S MAIDEN NAME FIRST ALICE MIDDLE PARKER LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-70-8839		17. INFORMANT HAROLD E. HARTSTACK SAME AS 13 HUSBAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper gastrointestinal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Diffuse Histiocytic Lymphoma</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>2000</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>6 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>October</u> , 19 <u>79</u> , to <u>12/23</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>G. Lennard Gold, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/23/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. LENNARD GOLD				22e. ADDRESS 8630 FENTON ST., SILVER SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/27/79		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE <u>Robert M. ...</u>			



Released by Dr. Ball

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 3 1 2 6 7 REG. NO.						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas M Harvey					12 2 79					11:45 P.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 25, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Montg. Bethesda					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5802 Greenlawn Dr.				
14. FATHER'S NAME FIRST MIDDLE LAST Ralph L. Harvey					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Thomas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 097-22-3505		17. INFORMANT ADDRESS Eleanor K. Harvey Same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4254 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE CARDIO MYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR 2 MO											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from SEPT. 29, 1979, to DEC. 1979, that (I) (was) last saw the deceased alive on NOV. 26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Leo M. Curtis M.D.					DEGREE M.D.			22c. DATE SIGNED 12-3-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leo M. Curtis, M.D.					22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 7, 1979		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Nantucket, Mass.				
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A. Bethesda, Md.					25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]				

100 N. Curtis, W.D. 1218 Wisconsin Ave. Bethesda, Md.
 Dec. 7, 1970 Prospect Hill Co. Washington, D.C.
 Robert A. Humphrey Funeral Home, W.D. Bethesda, Md.
 Leo M. Curtis, W.D. 1218 Wisconsin Ave. Bethesda, Md.
 Dec. 7, 1970 Prospect Hill Co. Washington, D.C.
 Robert A. Humphrey Funeral Home, W.D. Bethesda, Md.
 Yes Norman L. Harvey Eleanor E. Harvey Same as 15 Thomas
 Ralph L. Harvey Georgia Thomas
 Md. Mont. Bethesda X 5803 Greenway Dr.
 Bethesda Bethesda Hospital Lark U.S. Gov't.
 New York USA Montgomery
 Caucasian May 22, 1930 19
 Thomas M. Lark
 100 N. Curtis, W.D. 1218 Wisconsin Ave. Bethesda, Md.
 Dec. 7, 1970 Prospect Hill Co. Washington, D.C.
 Robert A. Humphrey Funeral Home, W.D. Bethesda, Md.
 Leo M. Curtis, W.D. 1218 Wisconsin Ave. Bethesda, Md.
 Dec. 7, 1970 Prospect Hill Co. Washington, D.C.
 Robert A. Humphrey Funeral Home, W.D. Bethesda, Md.
 Yes Norman L. Harvey Eleanor E. Harvey Same as 15 Thomas
 Ralph L. Harvey Georgia Thomas
 Md. Mont. Bethesda X 5803 Greenway Dr.
 Bethesda Bethesda Hospital Lark U.S. Gov't.
 New York USA Montgomery
 Caucasian May 22, 1930 19
 Thomas M. Lark



FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 6 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Virda Eudora Harwood			2a DATE OF DEATH MONTH DAY YEAR December 16, 1979		2b HOUR 4:45 P.M.
3 SEX Female	4 RACE Caucasion	5 DATE OF BIRTH MONTH DAY YEAR 9 4 1913		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS	7 UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ill.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home
13a STATE Md.			13b COUNTY P.G.	13c CITY OR TOWN Hyattsville	
14 FATHER'S NAME FIRST MIDDLE LAST Errett Pitzer		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Essie Williams			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 325-18-5608		17 INFORMANT ADDRESS Address Same as No # 13c.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Large cell lung cancer, Stage III 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from August 79 to 12-16 79, that (I) (we) lost saw the deceased alive on 12-15 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Kai-Yin Young, MD		DEGREE		22c DATE SIGNED 12-16-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Young, MD		22e ADDRESS 6525 Belview Rd # 460 Hyattsville, MD 20788			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12-20-79		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.	
23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.		25a DATE REG'D BY REGISTRAR DEC 19 1979			
24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyatts. Md.		25b REGISTRAR'S SIGNATURE [Signature]			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAM - 17
(VR A15 ME (5))
30M 7/73

FOR 1- STATE REGISTRAR												STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 31269			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST (Lydia) Myrtle Joy Haugen						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12/26 1979						2b. HOUR M 9:00 A. M															
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jul. 16, 1903		6. AGE (IN YEARS) (LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12/26 1979				7d. HOUR A. M											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minn.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.															
10. CITY OR TOWN OF DEATH Olney				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3913 Gelding Lane								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE California				13b. COUNTY				13c. CITY OR TOWN Dixon				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 595 Walnut Park Avenue													
14. FATHER'S NAME FIRST MIDDLE LAST Paul P Pauls						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Vang																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) None				16b. SOCIAL SECURITY NO. 475 28 8519				17. INFORMANT 3913 Gelding Lane Olney, Md. Lawrence Haugen (Son)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None																											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy M.D.				MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery, Md.				DATE SIGNED 12/26/79															
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 12/27/79				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE Fosston, Minn.															
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.												ADDRESS 11800 N.H.Ave.S.S.Md.				25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE 									

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Arthur H. Hayne						2a. DATE KNOWN OF DEATH ESTIMATED Dec 10 1979		2b. HOUR 8:30		
3. SEX Male	4. RACE White	5. DATE OF BIRTH Dec 25, 1945	6. AGE (IN YEARS) (LAST BIRTHDAY) 34 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD Dec 10 1979	2d. HOUR 8:30			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH in outgo many MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. STATE MD				13b. CITY OR TOWN Mont Bel. Spg		13c. STREET ADDRESS 504 Hillsboro Drive		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George H. Hayne			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary June McNabb			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 220-88-9534			17. INFORMANT Father: ADDRESS George H. Hayne, Silver Spring, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Palsy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Yr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None										
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Robert D. Rogers			TITLE (SPECIFY) Dep.			MEDICAL EXAMINER		DATE SIGNED Dec 11, 1979		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/12/79		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto., Co., Md.			
24. FUNERAL DIRECTOR NAME STEWART & MOWEN CO., 108 W. North Ave. 21201					25a. DATE REC'D. BY REGISTRAR DEC 19 1979		25b. REGISTRAR'S SIGNATURE			



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

31271

1. DECEASED NAME (TYPE OR PRINT) Roxie M. Head			2a. DATE KNOWN OF DEATH MATED Dec 30 1979		2b. HOUR 8:30	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH Sept DAY 23 YEAR 1909	6. AGE (IN YEARS) (LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	IF UNDER 24 HRS. HOURS 0 MIN 0	7c. DATE PRONOUNCED DEAD Dec 30 1979
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE MD			13b. COUNTY Prince Georges	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 718 Sheraton St
14. FATHER'S NAME FIRST John MIDDLE S. LAST Head			15. MOTHER'S MAIDEN NAME FIRST Lura MIDDLE Jones LAST Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) -----		16b. SOCIAL SECURITY NO. 220-48-6392		17. INFORMANT ADDRESS Ruth H. Folk-sister- (same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis' DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4409 (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 4409						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Fracture R. & L. Hips						
19a. DATE OF OPERATION DOCT. 18 1979 Nov 5 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Disloc. R. Hip Disloc. L. Hip				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:00 AM Nov 23 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell down stairs at home Fell out of bed in hospital		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Odessa Hospital		21f. LOCATION STREET Sheraton St CITY OR TOWN Hyattsville COUNTY Montgomery STATE MD		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) Dep.				MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME		ADDRESS Silver Spring, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Graniteville		23d. LOCATION CITY OR TOWN Graniteville COUNTY Aiken STATE S. Car
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc. ADDRESS 8434 Ga. Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE P. H. Rogers		



60% CO. 100%



JOSEPH

WILLIAM

11 25 20

WINTHROP CO.

SUBURBAN HOSPITAL

REYNOLDS

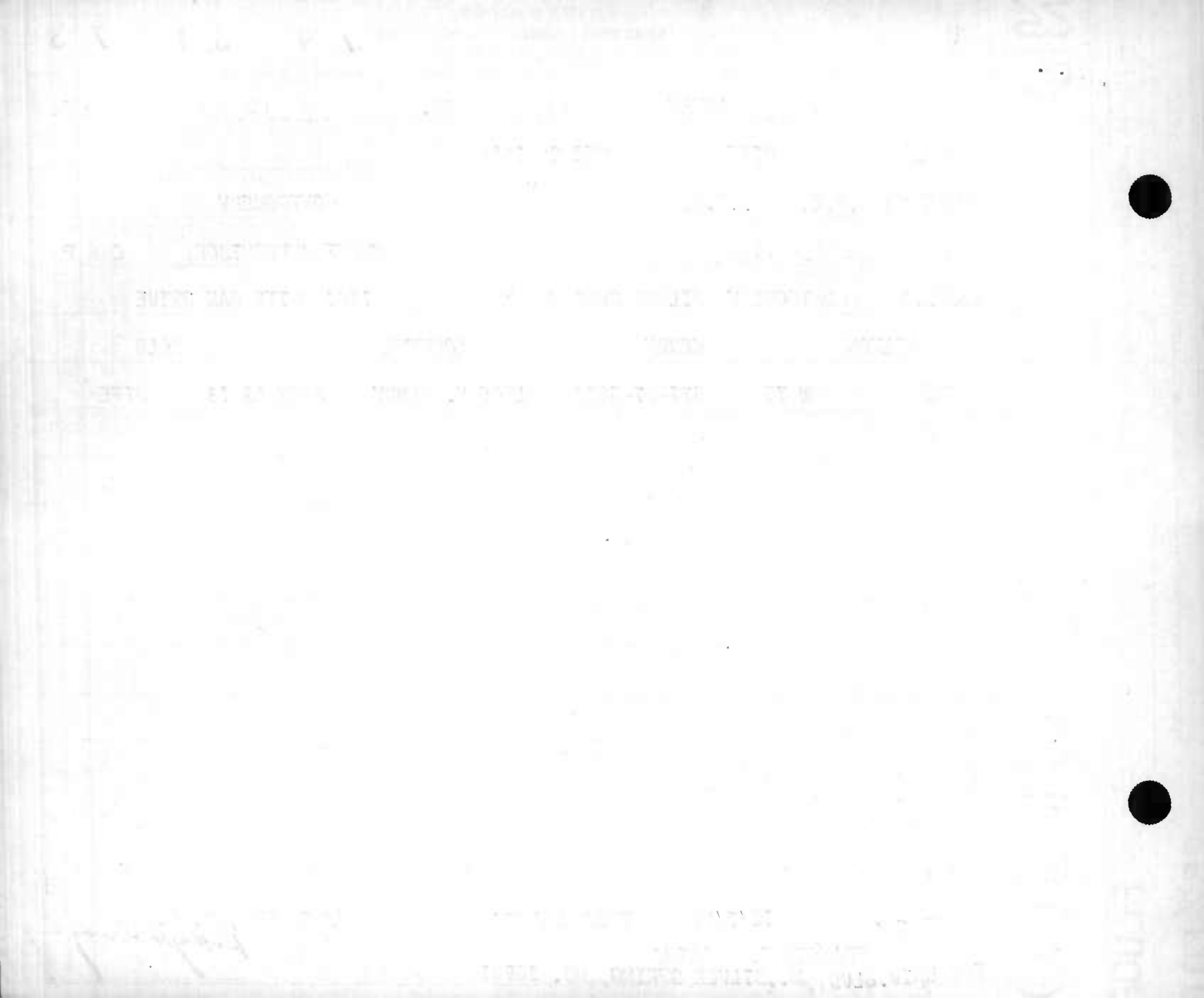
11th Street, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 7 3			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
MILTON		LYMAN		HENRY		SR.		12/5/79					1:45 A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		DEC 22, 1917		61		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
WASHINGTON, D.C.		U.S.A.				MONTGOMERY						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital		STAFF SUPERVISOR		C & P							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1702 WHITE OAK DRIVE					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
MILTON		HENRY		LORETTA		KOLB							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES		660 11		ALICE M. HENRY		SAME AS 13		WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										3 days.			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>hemorrhage</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>cancer of esophagus</u>										6 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>11/28/79</u> , 19____, to <u>12/5/79</u> , 19____, that (I) (we) last saw the deceased alive on <u>12/4/79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
<u>Deborah B. Goldberger</u>				12/5/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Deborah B. Goldberger		1106 Spring St. Silver Spring Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		12/7/79		PROSPECT HILL		WASHINGTON, D. C.							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. SIGNATURE							
FRANCIS J. COLLINS		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		DEC 6 1979		<u>Francis J. Collins</u>							

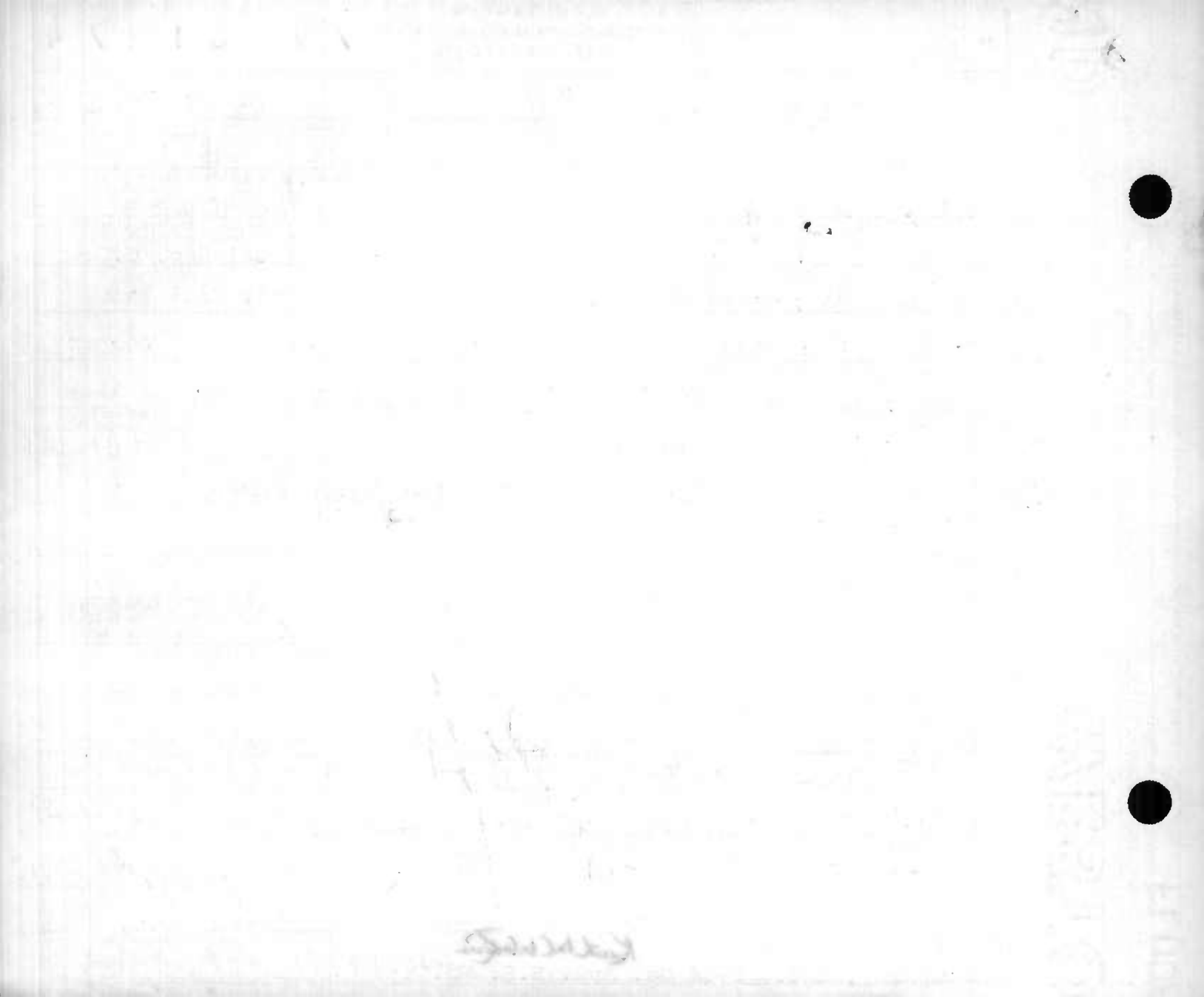


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.Cleared with Dr. Rogers
1 - Cleared with Dr. Rogers

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 2 7 4 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) George Cooper Hill				2. DATE OF DEATH 12 4 79				3. HOUR 5 10 7 PM			
3. SEX Male		4. RACE white		5. DATE OF BIRTH Sept. 17 1889		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Aeronautical Eng. U.S. Govt.		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1401 Blair Mill Road,	
14. FATHER'S NAME George Andrews Hill				15. MOTHER'S MAIDEN NAME Martha Lincoln Cooper							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. none		17. INFORMANT Nell G. Hill-wife-(same as 13e)		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia 496- DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pneumothorax											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 12/4 19 79 and that (2) the deceased was alive and (3) the deceased was seen by the body after death.											
22b. SIGNATURE Ralph E. Seligmann				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-4-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH E. SELIGMANN				22e. ADDRESS 8630 Fenton St. Silver Spring, Md. 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-7-79		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				ADDRESS 8434 Ga. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE L. H. McCready			



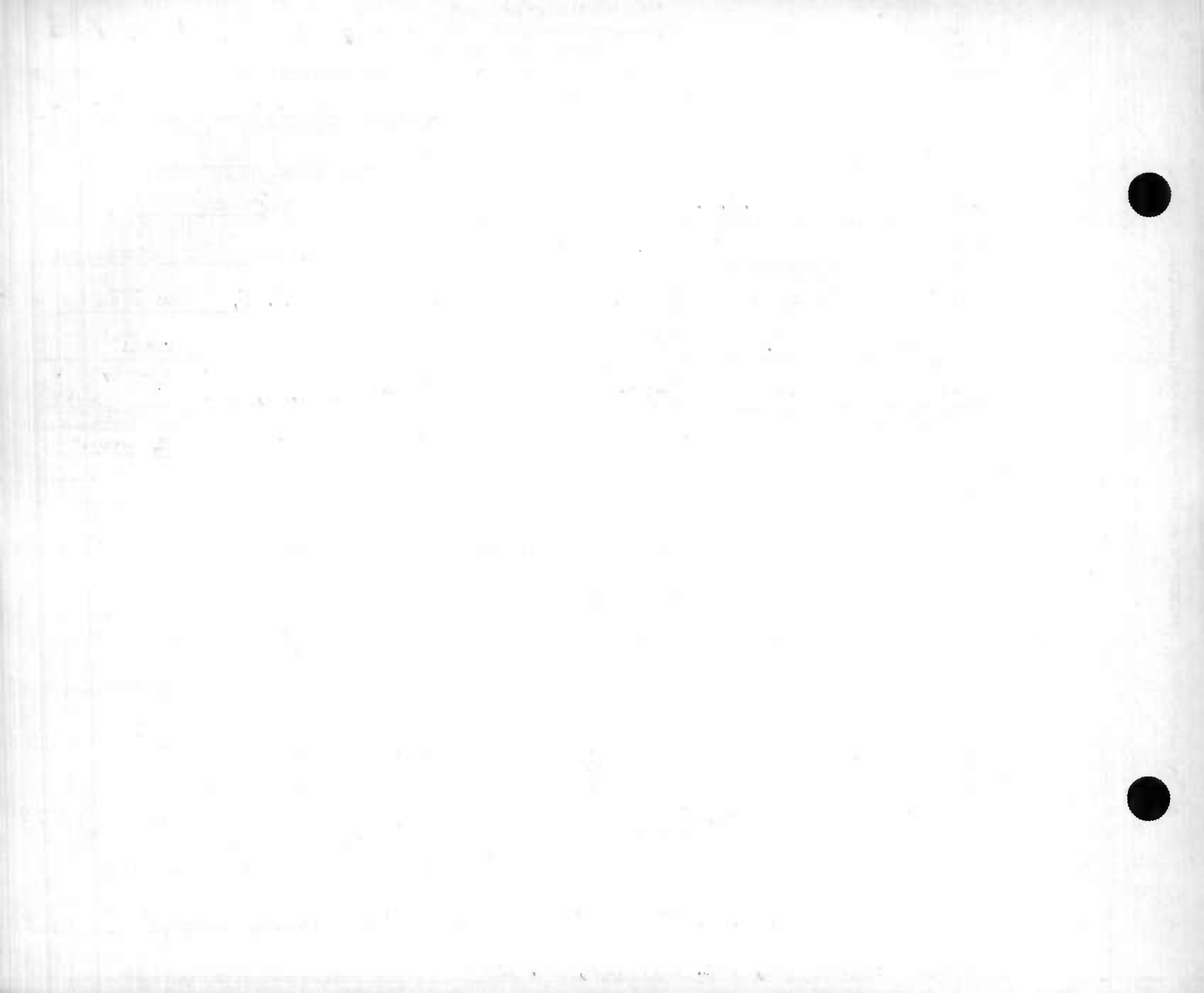
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 13 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

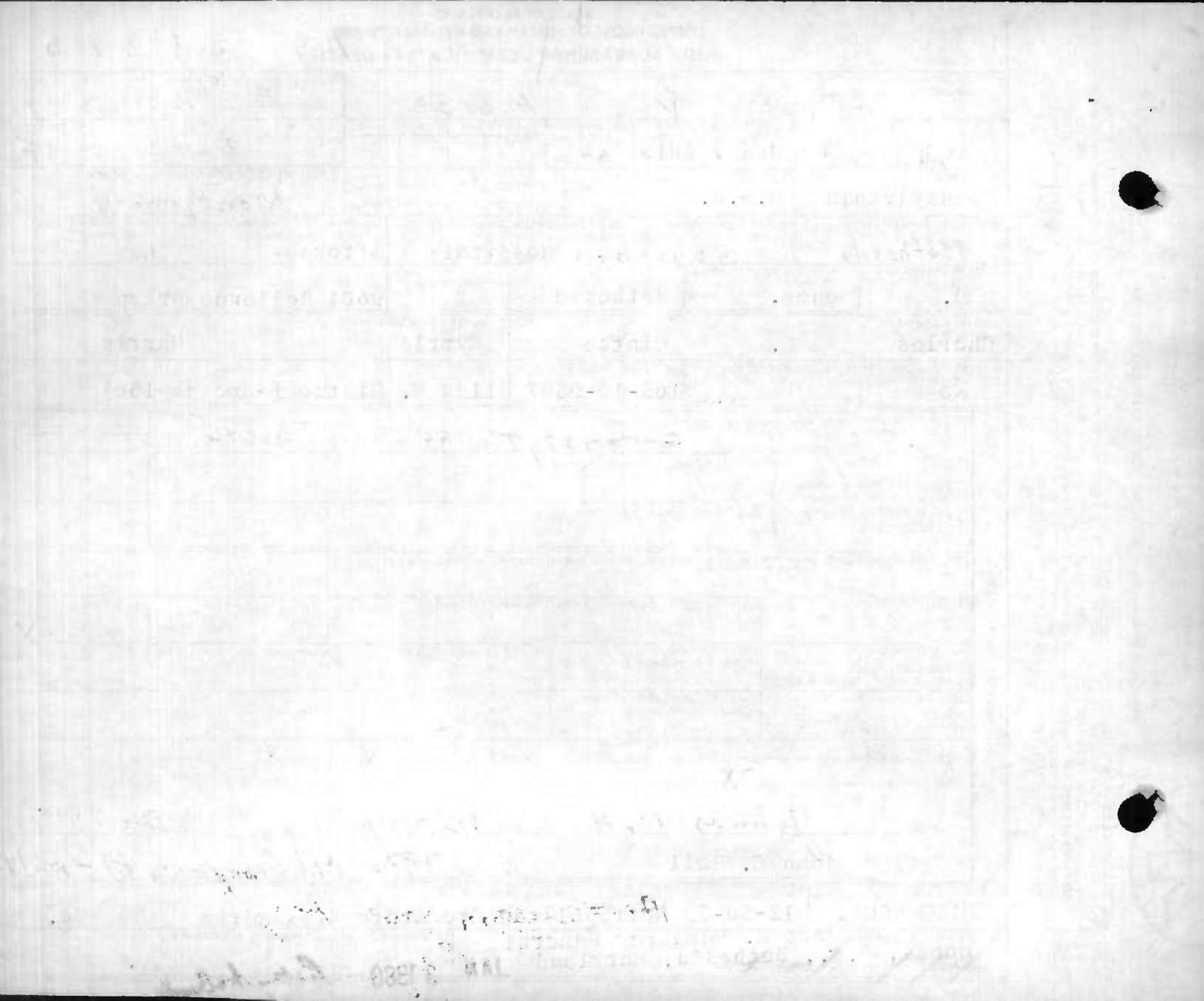
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 7 5	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) William Calvin Hill						2a. DATE OF DEATH MONTH DAY YEAR 12 - 9 - 79		2b. HOUR 4²⁰ A M			
3. SEX MALE		4. RACE CAY white		5. DATE OF BIRTH MONTH DAY YEAR 10 3 24		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Executive		12b. KIND OF BUSINESS OR INDUSTRY Pargas			
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Star Rt. 5, Box 487			
14. FATHER'S NAME FIRST MIDDLE LAST Walter C. Hill				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Sanders							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 00-11-422-12-0353		17. INFORMANT ADDRESS Rosemary Hill-Star Rt. 5, Box 487 20646							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma 1639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Large cell bronchogenic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 704 19 79 to Dec 9, 19 79 , that (I) (we) last saw the deceased alive on Dec 8 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Hubert J. Alpert				DEGREE M.D.				22c. DATE SIGNED Dec. 9, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT, M.D.				22e. ADDRESS 8630 FENTON ST. SILVER SPRING, MD. 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/12/1979		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Maryland					
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.				ADDRESS La Plata, MD. 20646		25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE Notary McCreedy			

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- STATE REGISTRAR		REG. NO. 31276									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Arthur		F		Hintze				2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
Male		White		Jan 7 1915		64 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. WIDOWED		11. DIVORCED	
Pennsylvania		U.S.A.		X							
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY		16. BALTIMORE CITY OR COUNTY OF DEATH		17. M.D.	
Bethesda		Suburban Hospital		Attorney		Law		Montgomery			
18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		19. STATE		20. COUNTY		21. CITY OR TOWN		22. INSIDE CITY LIMITS?		23. STREET ADDRESS	
		Md.		Montg.		Bethesda		YES X NO		9604 Bellevue Drive	
24. FATHER'S NAME		25. MOTHER'S MAIDEN NAME		26. WAS DECEASED EVER IN U.S. ARMED FORCES?		27. SOCIAL SECURITY NO.		28. INFORMANT		29. ADDRESS	
Charles		Myrtle		No		165-10-9897		Hilda M. Hintze		(Same as 13e)	
30. PART I DEATH WAS CAUSED BY:		31. IMMEDIATE CAUSE (a)		32. DUE TO, OR AS A CONSEQUENCE OF		33. (b)		34. DUE TO, OR AS A CONSEQUENCE OF		35. (c)	
411-		Coronary Insufficiency Acute.									
36. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		37. DATE OF OPERATION		38. CONDITION FOR WHICH OPERATION WAS PERFORMED?		39. AUTOPSY?		40. YES		41. NO	
						YES X NO					
42. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		43. TIME OF INJURY		44. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		45. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		46. CITY OR TOWN		47. COUNTY	
		P.M. 19									
48. INJURY OCCURRED WHILE AT WORK		49. NOT WHILE AT WORK		50. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		51. CITY OR TOWN		52. COUNTY		53. STATE	
54. I certify that I took charge of the remains described above, held on		55. Autopsy		56. Inspection		57. Inquiry		58. and in my opinion		59. death resulted from:	
		X		X		X				Natural causes X Accident X Suicide X Homicide X Undetermined manner X	
60. ACTUAL SIGNATURE		61. TITLE (SPECIFY)		62. DATE SIGNED		63. MEDICAL EXAMINER		64. DATE		65. SIGNED	
John G. Ball		Deputy		Dec. 28, 1979							
66. EXAMINER'S NAME (TYPE OR PRINT)		67. ADDRESS		68. BURIAL, CREMATION, REMOVAL (SPECIFY)		69. DATE		70. NAME OF CEMETERY OR CREMATORY		71. LOCATION	
John G. Ball		7936 Old Georgetown Rd. Bethesda, Md.		CREMATION		12-30-79		Metropolitan Crematory		Alexandria	
72. FUNERAL DIRECTOR		73. DATE REC'D. BY REGISTRAR		74. REGISTRAR'S SIGNATURE		75. DATE		76. REGISTRAR'S SIGNATURE		77. DATE	
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland		JAN 3 1980		[Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 7 7	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
MAYNARD G. HOGAN						12-12-79			11:40 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS		
Male		White		7-29-12			67 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA					Montgomery County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				Equip. Specialist		Govt.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13e. STREET ADDRESS					
William Hogan			Margaret Ollie Harrison			1221 Briggs Chaney Road					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT ADDRESS					
No			212-16-4954			1221 Briggs Chaney Road Clarice P. Hogan Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Cardiogenic Shock</i>										2 hrs	
4019 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i>										15 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
<i>Kidney Failure</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>12/1</i> , 19 <i>76</i> , to <i>12/12</i> , 19 <i>79</i> , that (I) was lost saw the deceased alive on <i>12/12</i> , 19 <i>79</i> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard C. Crapp</i>						DEGREE			22c. DATE SIGNED		
						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			12/14/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
C. Hogan						10620 6a Ave SS, or 1					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			Dec. 15, 79		Gate of Heaven			Silver Spring, Montg. Md.			
24. FUNERAL DIRECTOR NAME						25. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Hines/Rinaldi Funeral Home						DEC 19 1979			<i>[Signature]</i>		
11800 New Hampshire Ave. Silver Spring, Md.											



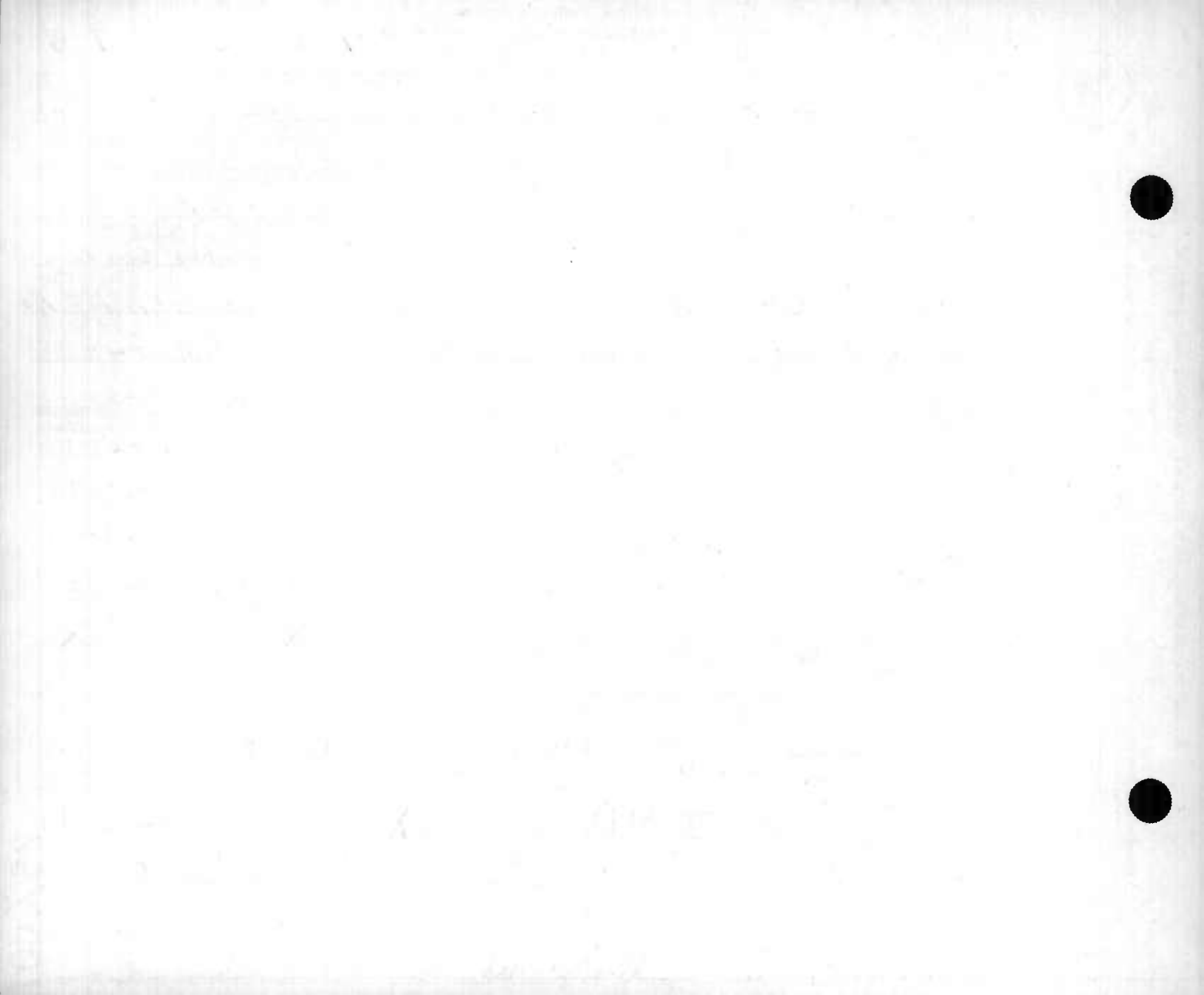
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 7 8	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE M. HOLESTIN					2a. DATE OF DEATH MONTH 12 DAY 3 YEAR 79			2b. HOUR 8⁰⁰ AM			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH APRIL DAY 13 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 74 HRS HOURS MIN. 	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVERSPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cable assembly Electric		12b. KIND OF BUSINESS OR INDUSTRY Co.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Laurel					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7213 Brock-Bridge Rd.				
14. FATHER'S NAME FIRST DOCTOR FRANKLIN MIDDLE HOWARD LAST SMITH					15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE SMITH LAST SMITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO 578 42 4369		17. INFORMANT ADDRESS HOWARD HOLESTIN ABOVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) UTI DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-27-79 11-27-79 11-27-79	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHF, Renal Failure, CVA, Diabetes Mellitus, Anemia											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NO P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) the hospital attended the deceased from 6-1-79 19____, to 12-3-79 19____, that (1) was last saw the deceased alive on 12-2-79 19____, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) was (did) not view the body after death.											
22b. SIGNATURE MB Patrick III MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-3-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Patrick III MD						22e. ADDRESS 4221 Colesville Rd Silver Spring, Md 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 5, 1979		23c. NAME OF CEMETERY OR CREMATORY IVY HILL CEM		23d. LOCATION CITY OR TOWN LAUREL COUNTY MD STATE				
24. FUNERAL DIRECTOR NAME Michael J. H. ADDRESS Laurel, Md						25a. DATE REC'D. BY REGISTRAR DEC 10 1979		25b. REGISTRAR'S SIGNATURE Patricia K. H.			

BP





FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 7 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy A. Holland</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12/6/79</i>		2b. HOUR MIN <i>1152 A</i>	
3 SEX <i>Female</i>	4 RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1 8 1916</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>63</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUBURBAN Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (YE) <i>Housewife</i>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>13- S.Ridge Rd.</i>
13a. STATE <i>Md.</i>	13b. COUNTY <i>Pr.Geo.</i>	13c. CITY OR TOWN <i>Greenbelt</i>		

14. FATHER'S NAME FIRST MIDDLE LAST <i>John P. Murray</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Beatrice Elwood</i>	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. <i>098-07-5287</i>	17. INFORMANT ADDRESS <i>George R. Holland - above address (Husband)</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic Failure</i> <i>5715</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Esophageal Variceal Bleeding</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cirrhosis of Liver</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 days</i> <i>7 days</i>
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION <i>11/30/79</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Variceal Bleeding</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from *11/30/79* to *12/6/79*, that I (we) lost
saw the deceased alive on *12/6/79*, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (If (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>G. Stuart Scott</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>12/6/79</i>
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. Stuart Scott</i>	22e. ADDRESS
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12/10/1979</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i>
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24. FUNERAL DIRECTOR NAME <i>Nalley's F.H. Inc.</i>	ADDRESS <i>Mt. Rainier, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>DEC 12 1979</i>	25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCurdy</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

Director - A

12/10/77

11 22 A

Female 1 8 1910 62

Montgomery

SUGARMAN

Mr. J. P. ... 11-1-1914 64

John P. ...
100-07-3207 ...
Bureau

© Street 2007

1 1/2 ... Silver ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					7 9 3 1 2 8 0				
CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACOB HOMES					2a. DATE OF DEATH MONTH DAY YEAR Dec. 25, 1979			2b. HOUR 4:05 a M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 18, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President		12b. KIND OF BUSINESS OR INDUSTRY Home Oil Co.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8201 - 16th Street	
14. FATHER'S NAME FIRST MIDDLE LAST Emanuel Homelsky					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Al DuGoff; 6336 Lenox Road, Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 10 YRS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 41 WEEKS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC OBSTRUCTIVE Lung Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 65 to 12-25 , 19 79 , that (I) (we) last saw the deceased alive on 12-20 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Herbert L. Tanenbaum, MD					DEGREE MD		22c. DATE SIGNED 12-25-79		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert L. Tanenbaum, M.D.					22e. ADDRESS 5480 Wisc., Ave., Chevy Chase, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-79		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike					25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE Walter McCreedy		

BP

THE UNIVERSITY OF CHICAGO
DIVISION OF THE PHYSICAL SCIENCES
DEPARTMENT OF CHEMISTRY

EXPERIMENT

DATE

1. Name of student _____

2. Name of instructor _____

3. Title of experiment _____

4. Summary of experiment _____

5. Results of experiment _____

6. Conclusions of experiment _____

7. Discussion of experiment _____

8. References _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Gene		Peter		Honchock				December 9, 1979		4:15 p.m.							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		Caucasian		6/16/20		59		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Pennsylvania		U.S.A.				Montgomery, MD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda		Suburban Hospital		President - Franklin & Insurance													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Montgomery		Bethesda						9921 Mayfield Drive							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Peter		Honchock				Mary		Wilhousky									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WWII		143-16-3820		Betty C. Honchock, same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
496- Respiratory Failure		CO PD				10 yrs 10 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
Ca of lung / Cor Pulmonale, Pulmonary																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from Sept 1970, to Dec 9 1979, that (I) saw the deceased alive on above, (I) viewed the body after death.		22b. SIGNATURE John S. Saia		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
John S. Saia, M.D.		809 Viers Mill Road Rockville, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		12/12/79		Culpeper National		Culpeper, Virginia											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND		DEC 12 1979		History McCreedy													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.				7 9 3 1 2 8 2		
1. DECEASED NAME (TYPE OR PRINT) <i>Robert S. HOPE</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12 - 28 - 79</i>			2b. HOUR <i>3:48</i> P.M.			
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10/8/23</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>56</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Missouri</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery CTY</i> MD			
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUBURBAN Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Attorney</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Law</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Damascus</i>		14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. STREET ADDRESS <i>27780 Ridge Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joe H. Hope, Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Belle Stocks</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII</i>		17. INFORMANT <i>Adrienne G. Hope, same as #13</i>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MASSIVE SUBDURAL HEMORRHAGE</i> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i> 20 YRS. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>PULMONARY HYPERTENSION</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <i>1970</i> 19____ to <i>12/28/79</i> 19____, that (I) (we) lost saw the deceased alive on <i>12/28/79</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)									
22b. SIGNATURE <i>Henry C. Scruggs, M.D.</i>				DEGREE				22c. DATE SIGNED <i>12/29/79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Henry C. Scruggs, M.D.</i>				22e. ADDRESS <i>5413 W. Cedar Lane, Bethesda, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>12/30/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory Alexandria, Virginia</i>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey Funeral Homes, P.A.</i>				24b. DATE REC'D. BY REGISTRAR <i>JAN 4 1980</i>		25b. REGISTRAR'S SIGNATURE			
7557 Wisconsin Ave., Bethesda, MD									



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 8 3

1. FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Minnie Hopkins			2a DATE OF DEATH MONTH DAY YEAR 12 05 79			2b HOUR 1:54AM				
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Mar. 25, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hosp.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Monta.		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 3301 Norbeck Road	
14 FATHER'S NAME FIRST MIDDLE LAST Unknown Edward Hopkins				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Dorsey						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 218-30-3546		17 INFORMANT ADDRESS Everett Holland (Nephew) 5421 Sargent Rd. Hyattsville, Md.				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 5070 DUE TO, OR AS A CONSEQUENCE OF b) _____ DUE TO, OR AS A CONSEQUENCE OF c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Lymphoma, mature, lymphocytic, mature cell extensive involvement since '72										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from 19 72 to Dec 5, 19 79 , that (I) (we) last saw the deceased alive on Dec 4, 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										
22b SIGNATURE Donald E. Dillon M.D. W. Friedrich Spooman, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12-5-79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, Md.						22e ADDRESS 18111 Prince Phillip Drive, Olney, Md.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 12-11-79		23c NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. Md.			
24 FUNERAL DIRECTOR NAME George R. Snowden						24b ADDRESS 246 N. Washington St. Rockville, Md. 20850		25a DATE REC'D. BY REGISTRAR DEC 11 1979		
25b REGISTRAR'S SIGNATURE <i>[Signature]</i>										

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 8 4

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Kathleen Gass Howe			2a. DATE OF DEATH MONTH DAY YEAR Dec 10, 1979			2b. HOUR M					
3 SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 5, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner Maternity Shop		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 299 Hurley Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Gass			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Cooper			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 532-69-4081	
17. INFORMANT ADDRESS Arl., Va.			Mrs. L. Gordon Huffines 3422A So. Utah St.								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary heart failure</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic heart Disease</u> 57 DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> 19 <u>75</u> to <u>12/10</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
21h. SIGNATURE <u>Myron L. Lenkin</u>			21i. DEGREE DEGREE			21j. DATE SIGNED <u>12/10/79</u>		21k. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22a. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN MD			22b. ADDRESS 2309 SHOREFIELD RD WHEATLEY MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation			23b. DATE 12-11-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.				
24. FUNERAL DIRECTOR NAME ADDRESS Everly-Wheatley Funeral Home, Alex., Va.						25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE <u>Kathy [Signature]</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPT 1919

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31285	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Agnes Howe										2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1979	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Sept 17 67		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.		IF UNDER 1 YR. MONTHS DAYS		2c. DATE PRONOUNCED DEAD December 28, 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN St. Pgs.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1530 W 211 Brock Ct. Spue			
14. FATHER'S NAME FIRST MIDDLE LAST Joshua Rodenhiser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Conway							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-36-7842A		17. INFORMANT ADDRESS Walter G. Howe, Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. [Signature]				DATE SIGNED Dec 28/1979			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/80		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE West Roxbury Mass.					
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND						25a. DATE REC'D. BY REGISTRAR JAN 3 1980 REGISTRAR'S SIGNATURE [Signature]					

Latent School Teacher

JAN 3 1980

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31286	
1. DECEASED NAME (TYPE OR PRINT) Mary Elizabeth Hubbard										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12/18 1979										2b. HOUR 7:05 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 20, 1896		6. AGE (IN YEARS) LAST BIRTHDAY 83 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 12/18 1979		24 HOUR A.M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.									
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 565 University Boulevard East				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laundry Employee				12b. KIND OF BUSINESS OR INDUSTRY Same									
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 565 University Boulevard East											
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Powell						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda ?															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214 12 7769		17. INFORMANT ADDRESS Arthur J. Hubbard, Sr															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypothermia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) exposure. DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Cerebral arteriosclerosis.																					
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE John S. Rogers, M.D.				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 12/18/79									
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 20, 1979		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md.											
24. FUNERAL DIRECTOR NAME John S. Rogers, M.D.				ADDRESS 257 Canal Drive DE				25a. DATE REC'D. BY REGISTRAR DEC 20 1979				25b. REGISTRAR'S SIGNATURE John S. Rogers									



Maryland

USA

Laundry Employee Name

Jacob

Powell

Matilda

214 12 758 Arthur J. Hubbard, Jr

no

DEC 4 1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

ITEMS 18a & b G540 2/22/80				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 3 1 2 8 7			
1. DECEASED NAME (TYPE OR PRINT) Patrick Louis Huff, Jr.				2a. DATE OF DEATH MONTH DAY YEAR December 19, 1979				2b. HOUR P M 5:45 P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 25, 1970		6. AGE (IN YEARS LAST BIRTHDAY) 9 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student School		12b. KIND OF BUSINESS OR INDUSTRY School			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Calvert Co. 13c. CITY OR TOWN Deale				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 706 Kingfisher Road 20751					
14. FATHER'S NAME FIRST MIDDLE LAST Patrick L. Huff				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brenda - (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mr. Patrick L. Huff, Sr. (same as above)							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF <u>Acute lymphoblastic leukemia</u> (b) <u>ACUTE LYMPHOBLASTIC LYMPHOMA</u> DUE TO, OR AS A CONSEQUENCE OF <u>PANCYTOPENIA</u> (c) <u>PANCYTOPENIA</u> Approximate interval between onset and death: <u>5 years</u> <u>4 1/2 yrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 5, 1979</u> to <u>December 19, 1979</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>December 19, 1979</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE <u>Amitabha Mazumder</u> M.D.				DEGREE M.D.				22c. DATE SIGNED 12/20/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMITABHA MAZUMDER				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec/22/79		23c. NAME OF CEMETERY OR CREMATORY Southern Memorial Garden				23d. LOCATION CITY OR TOWN COUNTY STATE Dunkirk, Calvert Co., Md.			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home				ADDRESS Riverdale, Maryland				25a. DATE RECEIVED BY REGISTRAR DEC 21 1979			



BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31288			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Juanita Pope Hughes										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12/17 19 79		2b. HOUR M 10:08 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1901		6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1207 Cresthaven Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1207 Cresthaven Drive				
14. FATHER'S NAME FIRST MIDDLE LAST Clinton C. Pope						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juanita Whitfield							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 418-38-0779		17. INFORMANT daughter Ann H. Hughes			ADDRESS same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) Deputy				DATE SIGNED 12/17/79					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 19, 1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.					
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR DEC 26 1979				25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>					
500 University Blvd., W. Silver Spring, Md.													



Handwritten notes and stamps, including a large circular stamp in the center and various illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

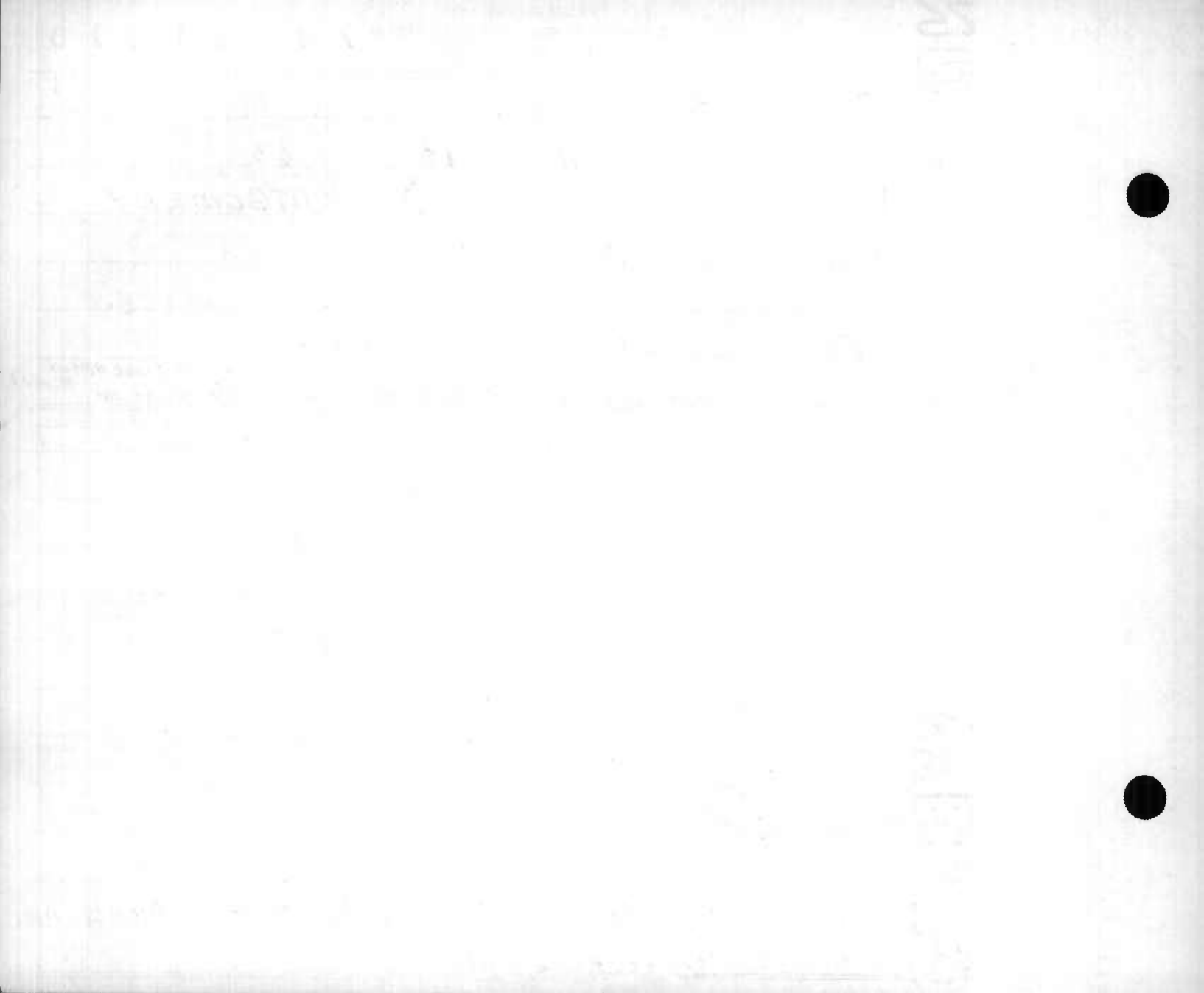
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR		7 9 3 1 2 8 9		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST Ida		MIDDLE Adeline		LAST Ingraham		2a. DATE OF DEATH		MONTH 12		DAY 20		YEAR 79		2b. HOUR 9:35 p.		MIN. M.	
3 SEX female		4 RACE white		5. DATE OF BIRTH		MONTH 4		DAY 16		YEAR 84		6 AGE (IN YEARS LAST BIRTHDAY) 95		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD													
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home																	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife,		12b. KIND OF BUSINESS OR INDUSTRY Own home																	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11208 Ashley Drive											
14. FATHER'S NAME		FIRST Wallace		MIDDLE B.		LAST Long		15. MOTHER'S MAIDEN NAME		FIRST Huldah		MIDDLE --		LAST Hartman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. --		17. INFORMANT Mrs. Ida Atchison, 11208 Ashley Dr. Rockville, Md. 20852															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 4392 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cerebrovascular Disease</u> (c) <u>Jeau</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>October 19, 1979</u> to <u>December 21, 1979</u> , that (I) (we) last saw the deceased <u>on December 21, 1979</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																			
22b. SIGNATURE <u>Bertram H. Arwin, M.D.</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-21-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bertram H. Arwin, M.D.				22e. ADDRESS 3720 Foun. St. Annapolis, Md. 20785															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/24/79				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park,				23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Allegany Maryland							
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				ADDRESS 1331 Rockville Pike Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 27 1979				25b. REGISTRAR'S SIGNATURE <u>John A. Brady</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 9 0									
1. FOR STATE REGISTRAR					REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR			
Joseph G. IMES										12 15 79				5 05		M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 72 HRS						
male		Black		MONTH DAY YEAR			63 YRS.			MONTHS DAYS			HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
Md.		USA						MONTGOMERY MD.											
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
SILVER SPRING					HOLY CROSS HOSPITAL					UNEMPLOYED									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)					13a. STATE					13b. COUNTY					13c. CITY OR TOWN				
Md.					Montgomery					Silver Spring					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					13e. STREET ADDRESS									
FIRST MIDDLE LAST					FIRST MIDDLE LAST					1135 ARCOLA AVE									
JOHN IMES					BERTIE														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS				
NO					214-18-8421					Alberta Blassingame					4297 Muncester Mill Rd. Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) 496- Congestive Heart Failure															6 days				
DUE TO, OR AS A CONSEQUENCE OF (b) CON Pulmonary																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																			
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
Alleged acute cardiovascular Disease																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
				HOUR A.M. MONTH DAY YEAR															
				P.M. 19															
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION											
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>								STREET				CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from October 1, 1979, to 12-15, 1979, that (I) (we) last saw the deceased alive on 12-14, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																			
22a. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED							
Morton A. Aitshuler MD												12/15/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS															
Morton Aitshuler MD				1299-2 LAMBERTON DR Silver Spring, Md															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				12-19-79				Poplar Grove Cem.				Germantown, Montg., Md.							
24. FUNERAL DIRECTOR				24b. ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
George R. Snowden				246 N. WASH. ST. Rockville, Md.				DEC 24 1979				[Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <i>Samuel E. Johnson</i>			7 9 3 1 2 9 1 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <i>Samuel Eugene Johnson</i>			2. DATE OF DEATH MONTH DAY YEAR <i>12 19 79</i>			2b. HOUR <i>6 35 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>BLACK</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 20 1928</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>51</i>		7. YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Porter</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>703 Monroe Street</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>JACOB S. JOHNSON</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>GLADYS E. NEAL</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218-20-2286</i>		17. INFORMANT ADDRESS <i>Dorothy JOHNSON (wife) same as #13</i>				
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intracerebral bleeding</i> <i>431-</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>aspiration pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>12-9-79</i> to <i>12-19-79</i> , that (I) (we) lost saw the deceased alive on <i>12-18-79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Hadi Bahar</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12-18-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HADI BAHAR</i>			22e. ADDRESS <i>8218 Wisconsin Ave. Bethesda Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12-22-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Paul Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Germantown Montg Md.</i>			
24. FUNERAL DIRECTOR NAME <i>George R. Snowden</i>			24b. ADDRESS <i>244 N. WASH. ST. Rockville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 24 1979</i>		25b. REGISTRAR'S SIGNATURE <i>H. J. Brady</i>		

1931 3 12 9 1

Feb 20 1938

U.S. N. 1

For 12

Mr. [illegible]

Dear Sir,

I am writing to you

regarding the

matter of the

contract for

the purchase of

the land for

the purpose of

the construction of

the dam for the

purpose of the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 2 9 2
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Zelma M Johnson			2a. DATE OF DEATH MONTH DAY YEAR 12 7 79			2b. HOUR 5¹⁵ PM						
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		7. IF UNDER 24 HRS HOURS MIN 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD						
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION/ (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager		12b. KIND OF BUSINESS OR INDUSTRY Hotel School				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1003 DeBeck Drive		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura H. Hershey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578 09 2000		17. INFORMANT ADDRESS Lawrence Kessel 8204 Baltimore Rd. College Park, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest 436- DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) ?										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 11125 Rockville Pike		CITY OR TOWN Rockville		STATE Md.		
22a. I certify that (this hospital) attended the deceased from 12-7-79 to 12-7-79 , that (we) lost saw the deceased alive on 12-7-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Carol Bender (David Stinski) MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-7-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol L Bender						22e. ADDRESS M.D. 11125 Rockville Pike Rockville, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/11/79		23c. NAME OF CEMETERY OR CREMATORY Fort Hill Cemetery			23d. LOCATION CITY OR TOWN Piqua, Ohio COUNTY Ohio STATE Ohio				
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND						25. DATE REC'D. BY REGISTRAR DEC 12 1979						
25b. REGISTRAR'S SIGNATURE Carol L Bender												



21 2 2 2

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Date

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR			
CONSTANCE GRANT JOHNSTON					29 DEC. 1979					7:30 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White		Feb. 23, 1887			92 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Scotland		U.S.A.					Montgomery MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		7722 Savannah Drive					Homemaker		At Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7722 Savannah Drive	
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
James -- Grant										Mary --		Cowie	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS									
No		---		080-40-6980 Rita Z. Johnston, Same as # 13.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary Arteriosclerotic Heart Disease</u> 1 year DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from 19 <u>71</u> to <u>12/29</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Joseph J. Wallace</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/29/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph J. Wallace				22e. ADDRESS 5272 River Rd., Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial/Transit		12/30/79		Mt. Hope		Rochester, New York							
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc., Wash., D.C. 20016				25a. DATE REC'D. BY REGISTRAR JAN 7 1980		25b. REGISTRAR'S SIGNATURE <u>Kathy McCreedy</u>							

MEDICAL CERTIFICATION



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR		7 9 3 1 2 9 4		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
John		A.		Kapp		Sr.		Dec.		17,		1979		9 P		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS									
Male		White		March 11, 1901		78		YRS		MONTHS		DAYS		HOURS		MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		USA				Montgomery												MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Takoma Park		8508 Glenville Rd.		retired-Western Electric															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md		Mont		T.P.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8508 Glenville Rd.											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Edwin V. Kapp		Emma Gault																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS													
None		577 09 9845		Viola B. Kapp (Wife)		Same as above													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> 2030 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>6-19-</u> 19 <u>76</u> , to <u>12-17</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-16</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED													
<u>Seruch T. Kimble MD</u>						12-18-79													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
Seruch T. Kimble		9801 Ga. Ave. Silver Spring, Md. 20902																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Burial		12/20/79		Ft. Lincoln Cemetery Brentwood		PG		MD.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Hines/Rinaldi		F.H. 11800 N.H. Ave. S.S. Md		DEC 20 1979		<u>[Signature]</u>													

1951 12 17



[Faint, illegible handwriting across the middle of the page, possibly a signature or address.]

DEC 30 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Baby Girl "A" KELLER			2a. DATE OF DEATH MONTH DAY YEAR December 14 1979			2b. HOUR 5:10P M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 14 1979		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 10		IF UNDER 1 YEAR IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY St. Mary's		13c. CITY OR TOWN Leonardtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 105-1	
14. FATHER'S NAME FIRST MIDDLE LAST Terry Lynn Keller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Jean Rice							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT ADDRESS Mrs. Susan J. Keller See item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 7651 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5:00 PM 5:10PM				
22a. I certify that (1) (this hospital) attended the deceased from Dec. 14 / 19 79, to Dec. 14 / 19 79, that (1) (we) last saw the deceased alive on Dec. 14 / 19 79, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. C. Albrecht M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Dec. 31, 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. C. ALBRECHT, M.D.			22e. ADDRESS National Naval Medical Center, Bethesda, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Dec. 17, 1979		23c. NAME OF CEMETERY OR CREMATORY National Naval Medical Center		23d. LOCATION CITY OR TOWN COUNTY STATE Nethesda Montgomery Md.			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 4 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

REPUBLICAN PARTY
STATE OF TEXAS
COUNTY OF []

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR M	
Baby Girl "B"		KELLER						Dec. 14 1979		5:15P	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		Dec. 14 1979						7	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Maryland		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		National Naval Medical Center		N/A							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		St. Mary's		Leonardtown				Route 1, Box 105-1			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Terry Lynn Keller		Sudan Jean Rice									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
N/A		N/A		Mrs. Susan J. Keller		See item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>7651</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE PM PM							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 14 5:08/19 79</u> to <u>Dec. 14 5:15/19 79</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 14 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R. C. [Signature]</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Dec. 31, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		Dec. 17, 1979		National Naval Medical Center		Bethesda Montgomery Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						JAN 4 1980					



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 2 9 7

1. DECEASED NAME (TYPE OR PRINT) Lenore F. Kemp			2a. DATE OF DEATH MONTH DAY YEAR 12 31 79			2b. HOUR 5:40p				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 26, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71		7. IF UNDER 1 YEAR MONTHS DAYS YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank teller		12b. KIND OF BUSINESS OR INDUSTRY Banking		
13a. STATE Maryland			13b. COUNTY Mont.		13c. CITY OR TOWN Sandy Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Frank Frederick Florstedt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lenora - Earp			13e. STREET ADDRESS 708 Olney-Sandy Spring Road				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 216-22-1126		17. INFORMANT ADDRESS Frank S. Kemp Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia with candidiasis DUE TO, OR AS A CONSEQUENCE OF (c) Collagen Vascular Disease - unclassified PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Collagen Vascular Disease - unclassified									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 12/15/79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED cholelithiasis			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 1 , 19 78 , to Dec 31 , 19 79 , that (1) (we) lost saw the deceased alive on Dec 31 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lewis Kellert, MD.			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/31/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellert, MD.			22e. ADDRESS 1311 Prince Phillip Dr. Olney, Md. 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 4, 1980		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md.			
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 20760			25a. DATE REC'D. BY REGISTRAR JAN 1 1980						25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18b G541 3/3/80 dad FOR 1 - STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 2 9 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pamela Jean Kerns										2a. DATE OF DEATH MONTH DAY YEAR December 26, 1979										2b. HOUR 3:40 a.m.			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1962			6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.														
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, (NIH)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student					12b. KIND OF BUSINESS OR INDUSTRY School								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia										13b. COUNTY Unknown			13c. CITY OR TOWN Strasburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Route 2, Box 74 22657				
14. FATHER'S NAME FIRST MIDDLE LAST James M. Kerns										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis Emerson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None			17. INFORMANT ADDRESS (same as above) Mrs. Phyllis Smith (mother)																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>1991</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Ewing's Sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years 10 mos</u> <u>-5 years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Dec. 17, 1979</u> to <u>Dec. 26, 1979</u> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on <u>Dec. 26, 1979</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> view the body after death.																							
22b. SIGNATURE <u>Carol Janus</u>										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>12/26/79</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CAROL JANUS</u>										22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md, 20205													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 29, 1979				23c. NAME OF CEMETERY OR CREMATORY Panorama Mem Gardens Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Warren County, Virginia											
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO. Silver Spring, Md. 20910										25a. DATE REV. D. BY REGISTRAR JAN 1 1980				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

For the year 1917

Amount of money received from the sale of the land in the year 1917

Amount of money received from the sale of the land in the year 1917

Amount of money received from the sale of the land in the year 1917

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward W. Kilmon			2a. DATE OF DEATH MONTH DAY YEAR December 3/ 1979			2b. HOUR 3:25 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 4 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Care Taker		12b. KIND OF BUSINESS OR INDUSTRY Golf Course	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4700 West Virginia Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas E. Kilmon					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Carter Grigria				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-07-5328		17. INFORMANT ADDRESS Jack E. Lehman 2405 Peachstone Ct. Silver Spring, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4/40 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 1 yr. 5 yrs				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): renal insufficiency					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/30/79 to Dec 79 , that (we) lost saw the deceased alive on 12/30/79 and that in our opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE Marvin Wadler, M.D.				22c. DATE SIGNED 12/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marvin Wadler, M.D.				22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-3-80		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR JAN 4 1980		25b. REGISTRAR'S SIGNATURE <i>Patricia McBrady</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE



TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text that are mostly illegible due to fading and bleed-through.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 3 0 0		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Harriet M. Kish				December 7 1979		5 30 P M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR IF UNDER 24 HRS	
Female		Cauc.		Jan. 7, 1899		80 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Wash., D.C.		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Colonial Villa Nursing Home		Beautician		--			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
New Jersey		--		Belle Mead		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17 Stephen Way	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Glendour		Medairy		Charlotte Amelia Kauffman		no		Belle Mead	
						577-07-2912		Charlotte Metzger, 17 Stephen Way, N.J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		1749 Metastatic breast Cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				August 19 79		December 19 79			
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
		mi)		12/8/79		JOEL BOOZIT		4701 RANDOLPH RD ROCKVILLE, MD 20852	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Dec. 10, 1979		Cedar Hill Cemetery		Suitland, Maryland			
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert G. Beall Lanham Funeral Home		DEC 14 1979							
9013 Annapolis Road, Lanham, Maryland									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

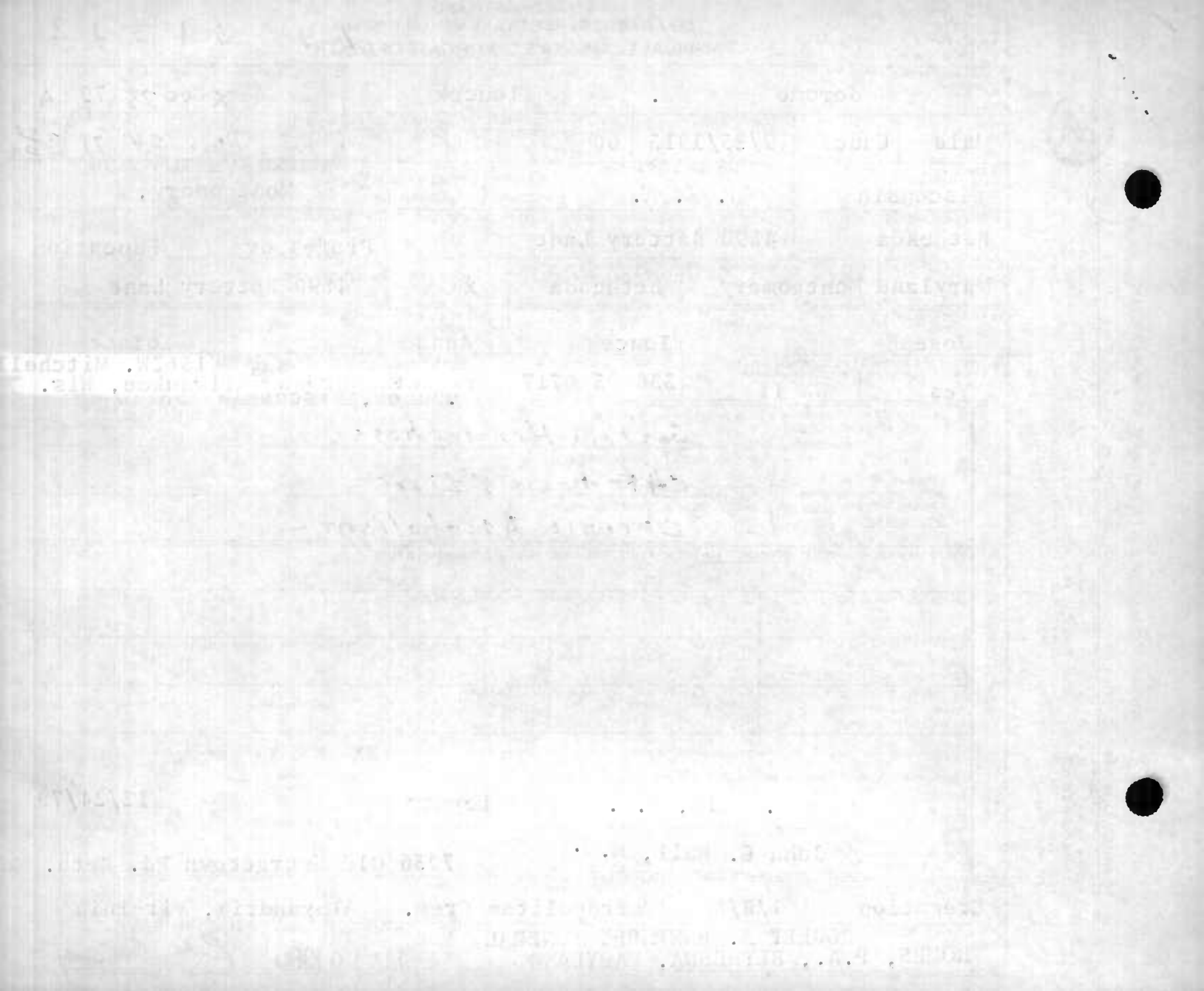
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		7b. HOUR	
Frank Klein			December 16, 1979		7:15am								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Male		White		Oct 25, 1901		78		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania		USA				Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Olney		Montgomery General Hospital		Merchant		TV Radio Re.							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Montgomery		Gaithersburg		NO		19056 Mills Choice Road			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Ignatz Klein				Regina (Unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				ADDRESS			
No				158-26-1227		Marjorie Klein; 19056 Mills Choice Road				Gaithersburg, Md.			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>anterior wall myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> 19 <u>79</u> to <u>12-16</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>12-16</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.				22b. SIGNATURE <u>Pasqual Perrino</u> PASQUAL V. PERRINO, M.D.				22c. DATE SIGNED <u>12-16-79</u> Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				12-17-79		Chesed Shel Ames		Neptune, Monmouth, New Jersey					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Danzansky-Goldberg Chapels; 1170 Rockville Pike				DEC 20 1979		<u>Ruby Goldberg</u>							

052 08230

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 31302					
1. DECEASED NAME (TYPE OR PRINT) Jerome W. Kloucek						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Dec 23, 1979			2b. HOUR A								
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 9/25/1913		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 66		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Dec - 24 1979		2d. HOUR 3:30 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.					
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS) 4890 Battery Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Professor				12b. KIND OF BUSINESS OR INDUSTRY Education					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS 4890 Battery Lane					
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kloucek						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kolasa											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Adele A. Meer, 4215 N. 100th St. Milwaukee, Wisconsin 53222											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Hemorrhage 5712 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Chronic Liver (b) Chronic Alcoholism (c) Chronic Alcoholism												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE John G. Ball				Deputy John G. Ball				DATE SIGNED 12/24/79									
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd. Beth. Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1/8/80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia							
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND						25a. DATE REC'D. BY REGISTRAR JAN 10 1980				25b. REGISTRAR'S SIGNATURE John G. Ball							



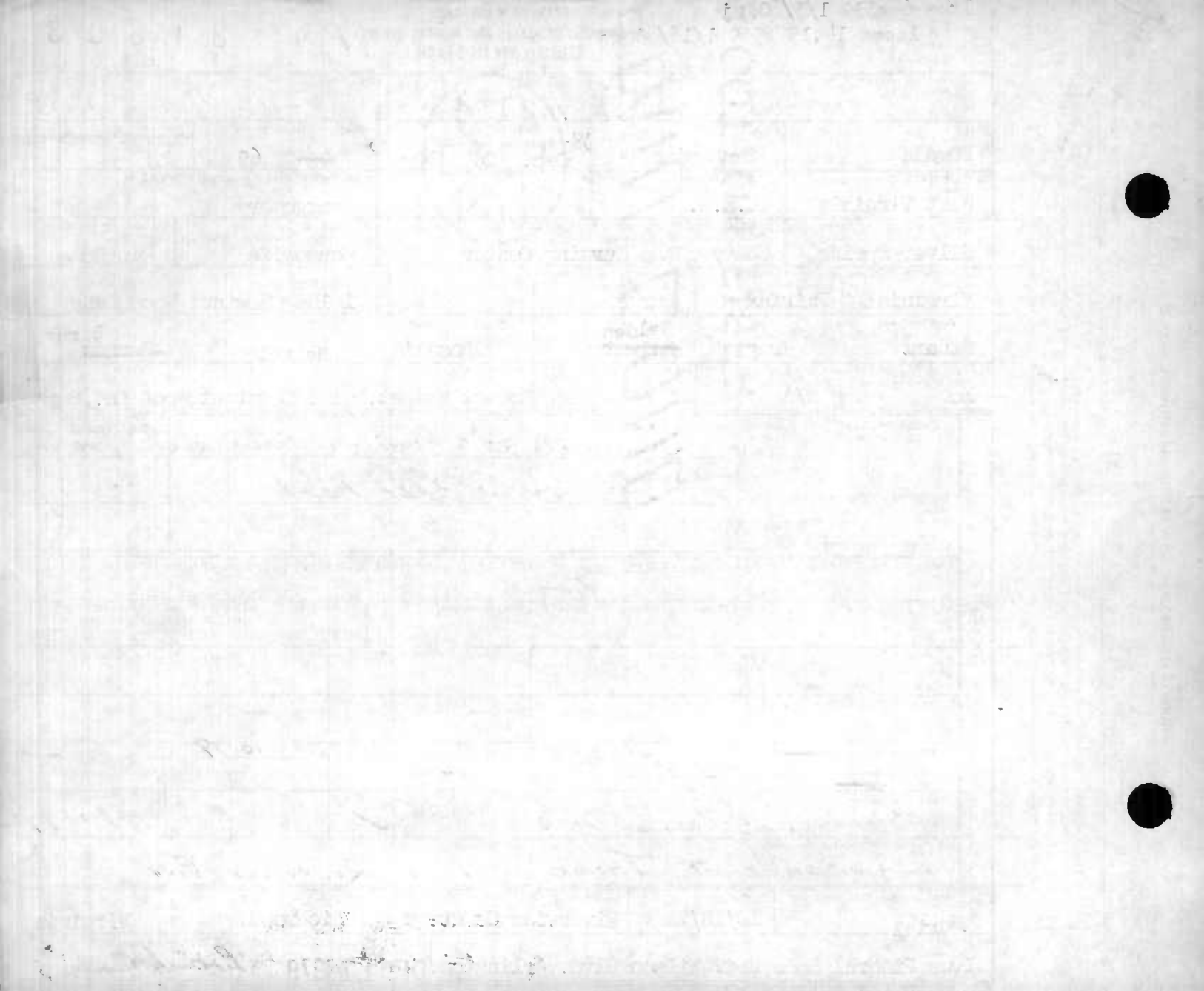
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

Item 6 6539 1/3/80 g3										STATE OF MARYLAND									
1. STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										2a. DATE OF DEATH MONTH DAY YEAR									
GWENDOLYNE S. KNIGHT										12-10-79									
3 SEX										4 RACE									
Female										Caucasian									
5. DATE OF BIRTH MONTH DAY YEAR										6 AGE (IN YEARS LAST BIRTHDAY)									
Dec. 24, 1909										78 69 YRS.									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b CITIZEN OF WHAT COUNTRY?									
West Virginia										U.S.A.									
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH									
Montgomery MD																			
10 CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Silver Spring										Chevy Chase Nursing Center									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY									
Housewife										Own Home									
13a STATE										13b COUNTY									
Virginia										Fairfax									
13c CITY OR TOWN										13d INSIDE CITY LIMITS?									
Burke										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
13e STREET ADDRESS																			
10104 Chestnut Wood Lane																			
14 FATHER'S NAME FIRST MIDDLE LAST										15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Stuart Wray Selden Knight										Rosalie Bethel Barnes									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b SOCIAL SECURITY NO.									
No										N/A									
17 INFORMANT ADDRESS										VA.									
Robert Knight, 10104 Chestnut Wood Ln., Burke																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4402										Generalized & Peripheral Arteriosclerosis 10 YRS.									
DUE TO, OR AS A CONSEQUENCE OF (b) Sanguine Left Foot										10 days									
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
None.																			
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a AUTOPSY?										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
										P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (the hospital) attended the deceased from DEC 75, 19, to DEC 10, 79, that (I) (we) last saw the deceased alive on Nov 30, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																			
22b. SIGNATURE										22c. DATE SIGNED									
Lawrence J. Thomas M.D.										12/10/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
LAWRENCE J. THOMAS										11801 ROCKVILLE PIKE									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE									
Burial										12/13/79									
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE									
Riverview Cemetery										Richmond, Virginia									
24. FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR									
Ives Funeral Home, 2847 Wilson Blvd., Arlington, VA.										DEC 17 1979									
25b. REGISTRAR'S SIGNATURE																			
L. J. Thomas																			

BP



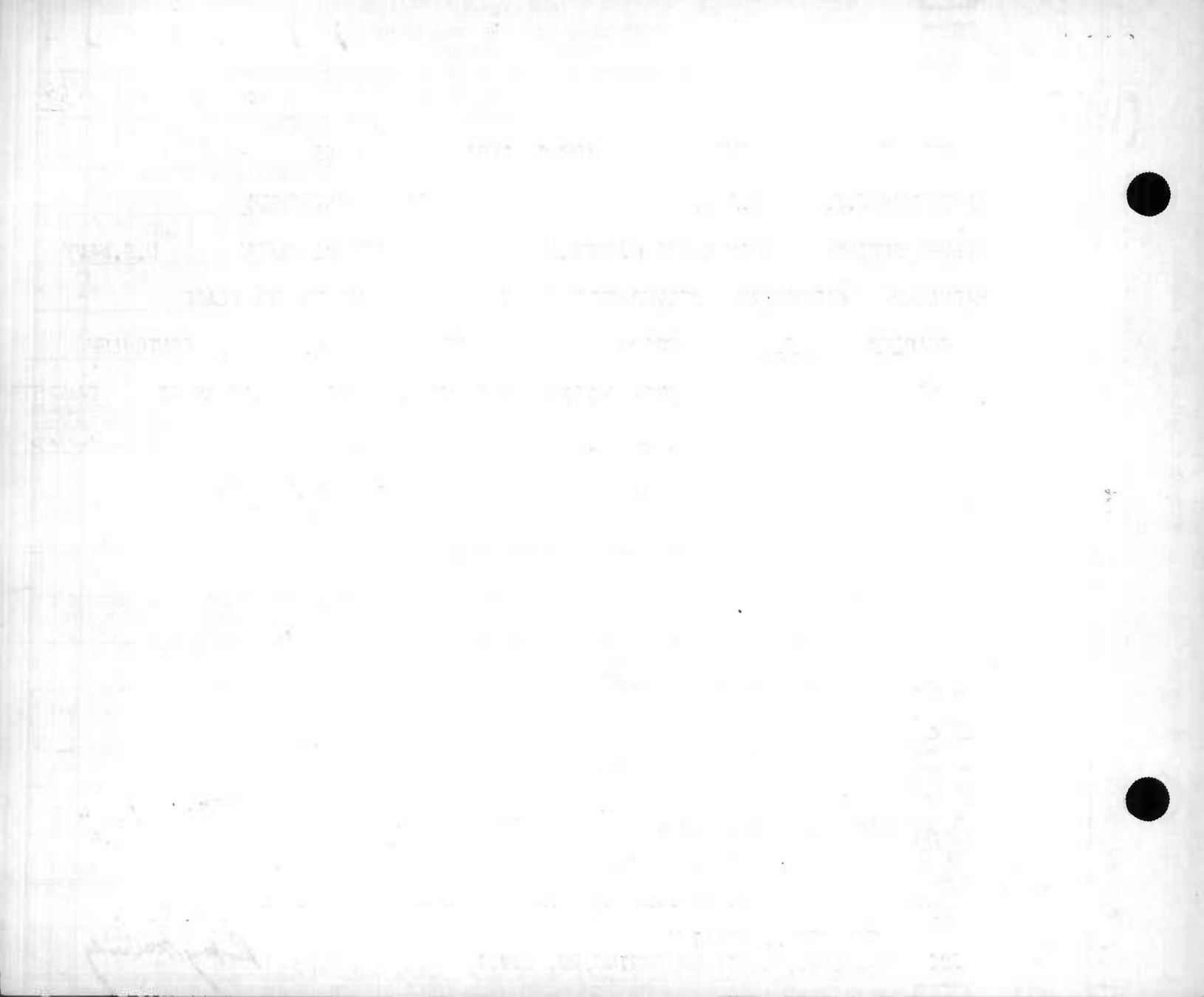
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					7 9 3 1 3 0 4 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Catherine A. Koerber					2a. DATE OF DEATH MONTH 12 DAY 23 YEAR 79				2b. HOUR 11:06 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH AUG 2 , DAY 1894 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FISCAL CLERK		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 403 THAYER PLACE			
14. FATHER'S NAME FIRST CHARLES MIDDLE J. LAST BROWN					15. MOTHER'S MAIDEN NAME FIRST EDITH MIDDLE M. LAST CRUTCHLEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 577-60-7178		17. INFORMANT MARGARET E. EWELL			17. ADDRESS SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock 440- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few hours					PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12/23 , 19 79 , to 12/23 , 19 79 , that (I) (we) lost saw the deceased alive on 12/23 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Antonio G. Uy DEGREE MD					22c. DATE SIGNED 12/23/79			22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO G. UY MD.		
22e. ADDRESS 831 Univ. Blvd. S Silver Spring, Md 20903										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 29, 1979		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN WASHINGTON, D.C. COUNTY STATE				
24. FUNERAL DIRECTOR FRANCIS J. COLLINS NAME ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE Ricky McBrady			



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 0 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David Warren Koopman			2a. DATE OF DEATH MONTH DAY YEAR December 21, 1979		2b. HOUR 3:55P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 14, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research Physicist Univ. Md.	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Mont.	13c. CITY OR TOWN Brookeville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Philip U. Koopman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emiline McFaul		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 503-40-5114	17. INFORMANT John Koopman 119 Fairhill Drive Churchville, Pa.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of appendix</u> 1535- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Duodenal obstruction, gastrostomy, hypernatremia, retroperitoneal & liver metast.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>79</u> to <u>21 Dec</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>21 Dec</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated <u>above</u> (did) (did not) view the body after death.					
22b. SIGNATURE <u>Donald E. Dillon MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 21 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon		22e. ADDRESS Olney, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-22-79	23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR'S NAME Francis J. Collins		ADDRESS 500 University Blvd. W., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR DEC 26 1979	25b. REGISTRAR'S SIGNATURE <u>Ruby M. Brady</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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Journal of Management Education

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 0 6

REG. NO.

1- FOR STATE REGISTRAR LAURIE

1 DECEASED NAME (TYPE OR PRINT) <u>LAURIE</u> <u>KOSTECK</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>12-31-79</u>		2b. HOUR <u>3 16 PM</u>	
3 SEX <u>F</u>	4 RACE <u>Cauc.</u>	5 DATE OF BIRTH MONTH DAY YEAR <u>73</u>	6 AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Russia</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD		
10 CITY OR TOWN OF DEATH <u>BETHESDA</u> <u>ROCKVILLE</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Clerk</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>County gov't</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>MD</u> 13c. COUNTY <u>Mont</u> 13d. CITY OR TOWN <u>Rockville</u>		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <u>199 Rollins Ave.</u>		
14 FATHER'S NAME FIRST MIDDLE LAST <u>Michael</u> <u>Kosteck</u>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Johanna</u> <u>Piglich</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>486-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>G Dehydration - Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>PM</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>28 Dec 1979</u> to <u>31 Dec 1979</u> , that (I) (we) lost <u>30 Dec 1979</u> saw the deceased alive on <u>30 Dec 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>David J. Jones</u>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>	23b. DATE <u>1/3/80</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
24 FUNERAL DIRECTOR NAME <u>Anatomy Board</u>		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>JAN 9 1980</u>	
ADDRESS <u>Balto., Md.</u>			

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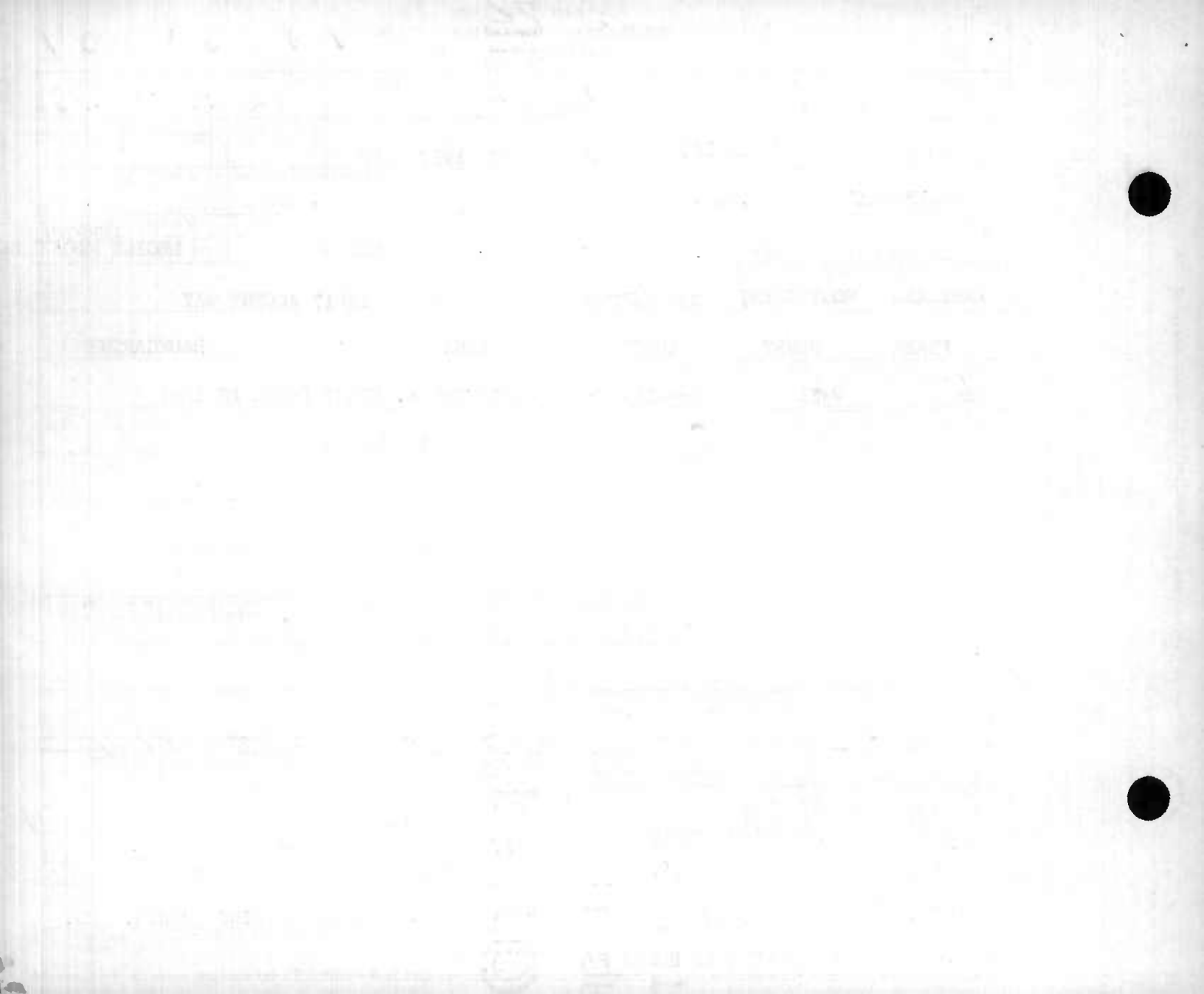
DHMH-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 3 0 7 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK H. KUEST				12 25 79 4 10 PM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 22 1917		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EDITOR		12b. KIND OF BUSINESS OR INDUSTRY AMERICAN LEGION MAGAZINE	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GERMANTOWN	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK HENRY KUEST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA BAUMGARTNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII				16b. SOCIAL SECURITY NO. 569-16-6762		17. INFORMANT ADDRESS ELIZABETH K. KUEST (SAME AS 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 1919 Glioblastoma Multiforme DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c):							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION 12/20/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain tumor		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 12/18 19 79 to 12/25 19 79 , that (II) (we) last saw the deceased alive on 12/24 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE Ralph E. Seidmann M.D.				22c. DATE SIGNED 12/25/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH E SEIDMANN	
22e. ADDRESS 8630 FENTON ST. SIL. SPR. MD 20910				23a. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.			
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23c. DATE 12-28-79		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTG. MD.		23e. DATE REC'D. BY REGISTRAR JAN 2 1980	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A				24b. ADDRESS ROCKVILLE MD.		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		2c. MIN	
1. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES		MIDDLE FRANCIS		LAST LAMBORN		Dec. 18 1979 3:25 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
Male		White		9 17 1964		75 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
D.C.		U.S.A.				Montgomery MD.		10b. KIND OF BUSINESS OR INDUSTRY	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12c. RETIRED	
Bethesda		Suburban Hospital		Retired Teller		Retired			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
D.C.				Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3750 Jocelyn St. N.W.	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT	
Charles		Fanny		No		577-22-1996		Emily M. Lamborn. Wife. Same as item 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arrhythmia</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
4249						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bacterial Endocarditis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Valvular Heart Disease + Pericarditis</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION		21e. DATE SIGNED	
		HOUR A.M. MONTH DAY YEAR				CITY OR TOWN COUNTY STATE		12-10-79	
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION		21e. DATE SIGNED	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						CITY OR TOWN COUNTY STATE		12-10-79	
22a. I certify that (I) (this hospital) attended the deceased from 12-8 1979 to 12-10 1979, that (I) (we) last saw the deceased alive on 12-9 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		22d. ADDRESS		22e. SIGNATURE	
William F. Luckett		M.D.		12-10-79		5000 Reno Rd. N. W. Wash., D. C. 20008			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. DATE		22d. ADDRESS		22e. SIGNATURE		22f. SIGNATURE	
William F. Luckett		12/19/1979		5000 Reno Rd. N. W. Wash., D. C. 20008					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. NAME OF CEMETERY OR CREMATORY		23c. LOCATION		23d. COUNTY		23e. STATE	
Cremation		Ceram Hill Crematory		Suitland		Maryland			
24 FUNERAL DIRECTOR		24b. DATE		24c. ADDRESS		24d. CITY OR TOWN		24e. STATE	
Joseph Gawler's Sons Inc.		12/19/1979		5130 Wisc. Ave., N.W. Wash., D.C.		Suitland			
25. DATE		25b. SIGNATURE		25c. SIGNATURE		25d. SIGNATURE		25e. SIGNATURE	
DEC 20 1979									

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #10a-22a Film G539 1/21/80 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										7 9 3 1 3 0 9 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Raymond Earl Langley						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 7 19 79				2b. HOUR M 4:30 P M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 27 1948		6. AGE (IN YEARS) LAST BIRTHDAY 31 YRS.		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Gaithersburg			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 416 N. Summit Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Safeway Stores	
13a. STATE Maryland			13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 416 N. Summit Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Raymond A. Langley						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Irmalee Headden						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam			17. INFORMANT ADDRESS Linda L. Langley 88 W. Deer Park Rd., T3 Gaithersburg, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3459 IMMEDIATE CAUSE (a) Seizure disorder (idiopathic epilepsy) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant				DATE SIGNED 12/8/79				
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 12-12-79		23c. NAME OF CEMETERY OR CREMATORY Veterans Cheltenham Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.				
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A				ADDRESS ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR DEC 17 1979			25b. REGISTRAR'S SIGNATURE [Signature]			

31. 6. 20

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HRS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31310	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eloise R. Laster										20. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 26 19 79	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR March 28, 1952	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 27 YRS.	7. DATE OF BIRTH MONTH DAY YEAR March 28, 1952	8. DATE OF BIRTH MONTH DAY YEAR March 28, 1952	9. DATE OF BIRTH MONTH DAY YEAR March 28, 1952	10. DATE OF BIRTH MONTH DAY YEAR March 28, 1952	11. DATE OF BIRTH MONTH DAY YEAR March 28, 1952	12. DATE OF BIRTH MONTH DAY YEAR March 28, 1952	13. DATE OF BIRTH MONTH DAY YEAR March 28, 1952	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CARLISE, PA.			7b. CITIZEN OF WHAT COUNTRY? UNITED STATES			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TECHNICIAN			12b. KIND OF BUSINESS OR INDUSTRY PVT.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY P. G.		13c. CITY OR TOWN Hillcrest, Hgts., MD.		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 2516 COLBROOK DRIVE,			
14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY CURLEY			16. ADDRESS CAPITOL HGTS., MD. MRS. MARY JOHNSON/MOTHER/406 ZELMA AVENUE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 57-7-724			17. INFORMANT ADDRESS MRS. MARY JOHNSON/MOTHER/406 ZELMA AVENUE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypoxic encephalopathy complicating anesthesia DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:20 AM 12/19/79			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) hypotension & lung collapse during anes-					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hospital			21f. LOCATION STREET CITY OR TOWN COUNTY STATE Washington Adventist Hosp. Takoma Pk., Mont., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith, M.D.			TITLE (SPECIFY) Deputy Chief			MEDICAL EXAMINER			DATE SIGNED 12/28/79		
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE Jan. 2, 1980			23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER PG. MARYLAND		
24. FUNERAL DIRECTOR NAME ROLLINS FUNERAL HOME, INC.			ADDRESS 4339 HUNT PL. N. E.			25a. DATE REC'D. BY REGISTRAR JAN 3 1980			25b. REGISTRAR'S SIGNATURE R. J. H. H. H.		

72 22-51 2 10/11/11

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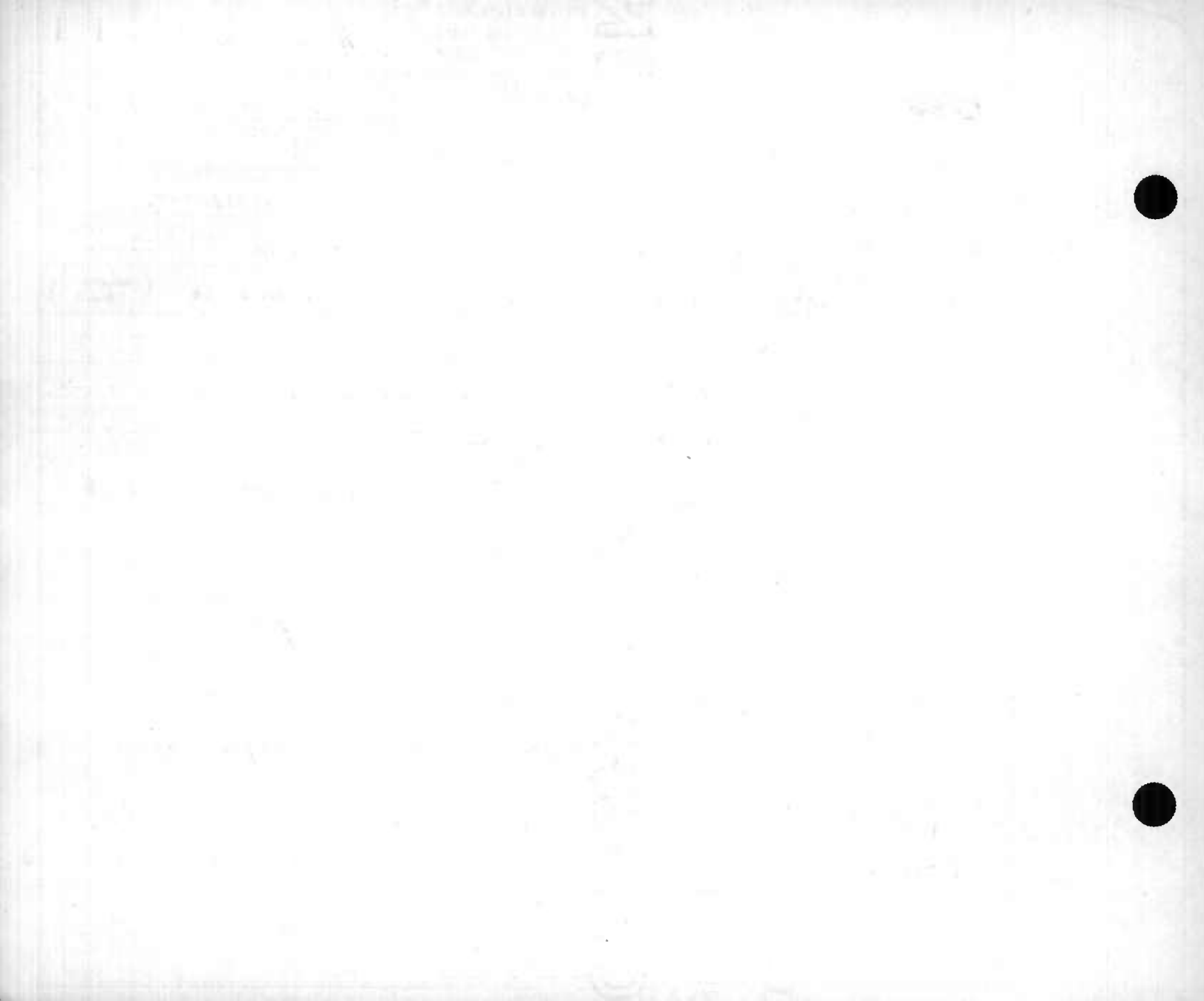
10-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR				7 9 3 1 3 1 1				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
Elsie Leopold				12 22 79				11 08 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		Cauc		12 16 91		88 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York		USA				montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross		Housewife		-----			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS		13c. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6121 Montrose Rd. (Hebrew Home)			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
(unknown)				(unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				087-18-8303		Joel H. Broida; 6091 Moongong Ct., Columbia Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure w/ pulmonary edema								24 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c) A-H-D								2 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Renal Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/22, 19 79, to 12/22, 19 79, that (I) (we) lost saw the deceased alive on 12/22, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Peter B. Sherer				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter B. Sherer MD				22e. ADDRESS 6410 Rockledge Dr. #308 Bethesda, Md. 20034					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-26-79		23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elmont, L.I., New York			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 1 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Samuel A LEVIN			2a. DATE OF DEATH MONTH DAY YEAR 12 - 16 - 79			2b. HOUR 2:48 P.M.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 - 3 - 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHIPPING CLERK		12b. KIND OF BUSINESS OR INDUSTRY APPLIANCE		
13a. STATE Md.			13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2423 Chapman Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS LEVIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH MINTZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-03-2838			17. INFORMANT ADDRESS ARTHUR LEVIN, 2423 CHAPMAN ROAD, HYATTSVILLE, MARYLAND				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock 410- DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hr. 12 hr.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) GI Bleeding, Diabetes mellitus										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/16/79 to 12/16/79, that (I) (we) lost saw the deceased alive on 12/16/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we did) (did not) view the body after death.										
22b. SIGNATURE Keith M. Lindgren M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/17/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith M. Lindgren, M.D.						22e. ADDRESS 7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/19/1979		23c. NAME OF CEMETERY OR CREMATORY CONGREGATION BETH SHOLOM CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE PITTSBURGH PENNSYLVANIA			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR DEC 19 1979		25b. REGISTRAR'S SIGNATURE R. H. H. H.		

MEDICAL CERTIFICATION

29

5801 BP

12-20-2

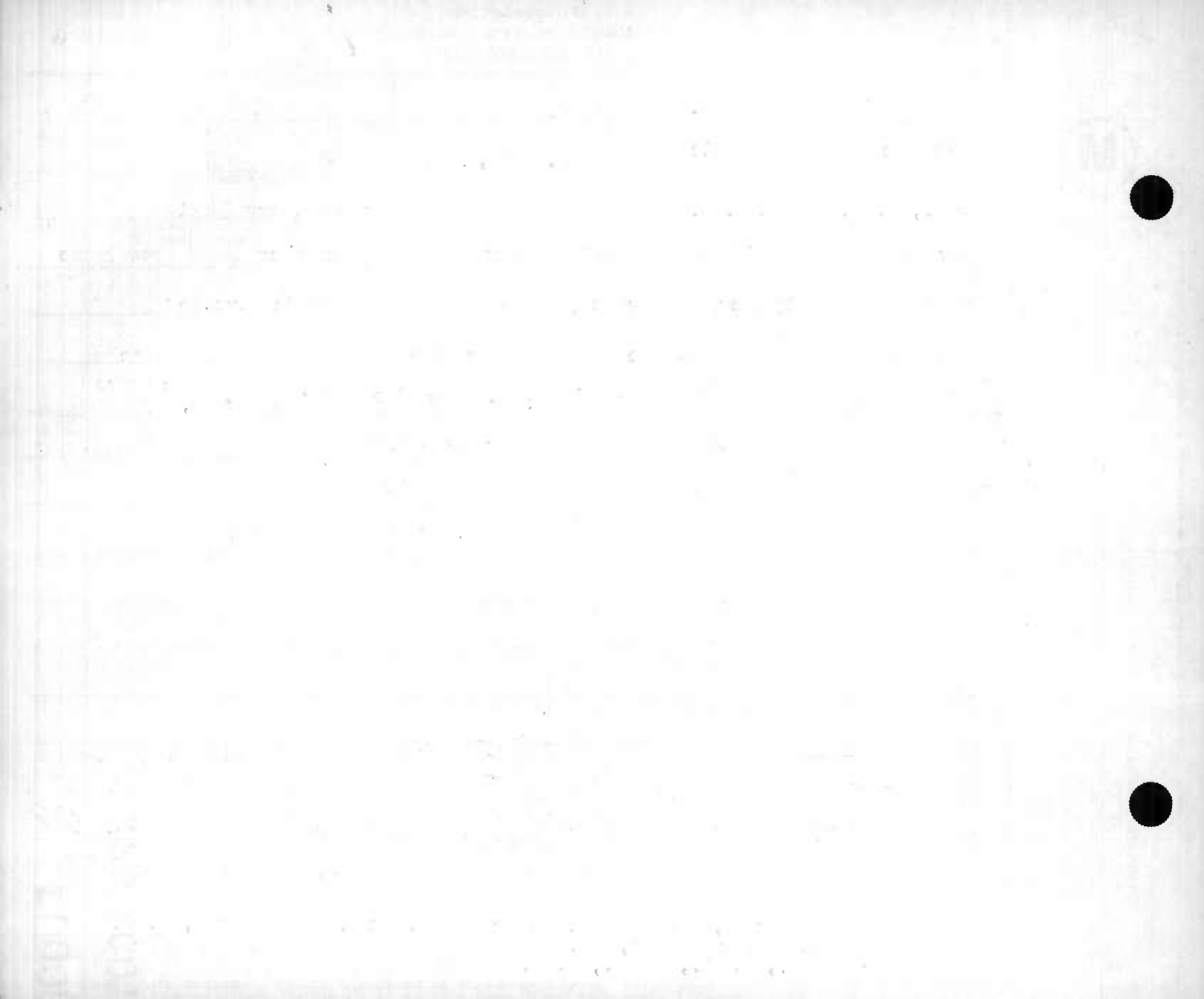


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 9 3 1 3 1 3 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Julia K. Levy			2a. DATE OF DEATH MONTH DAY YEAR 12 3 79			2b. HOUR 5:45 ^{PM}			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 299 Hurley Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Max Kohner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Michaelis			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16a. SOCIAL SECURITY NO. 579-68-5972			17. INFORMANT ADDRESS Mrs. Josephine Zukav 13719 Drake Drive Rockville, Maryland			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4370 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cerebrovascular disease (c) nasular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 50 PM 12 3 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the hospital) attended the deceased from 8 Sept 19 79 , to 3 Dec 19 79 , that it (we) last saw the deceased alive on 30 NOV 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22a. SIGNATURE Walter E. Goetz DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 3 Dec 79			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOETZ MD						22d. ADDRESS 2309 SHOREFIELD RD WHEATON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 5, 1979		23c. NAME OF CEMETERY OR CREMATORY Wash. Hebrew Cong. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.						25a. DATE REC'D. BY REGISTRAR DEC 7 1979			
25b. REGISTRAR'S SIGNATURE notary						25c. REGISTRAR'S SIGNATURE notary			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMM - 17
(VR 15 ME (5))
30M 7/73

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31314			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vivian Levy										ESTIMATED <input checked="" type="checkbox"/> 11 19 79		M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH JULY 13, 1956		6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 11 20 79		2d. HOUR 2:14 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) EGYPT				7b. CITIZEN OF WHAT COUNTRY? UNKNOWN				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ramada Inn, Route 28				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT				12b. KIND OF BUSINESS OR INDUSTRY SCHOOL	
13a. STATE RHODE ISLAND				13b. COUNTY PROVIDENCE				13d. INSIDE CITY LIMITS? XXX NO <input type="checkbox"/>		13e. STREET ADDRESS 650 HOPE ST. (02906)			
14. FATHER'S NAME FIRST MIDDLE LAST MAURICE LEVY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUZANNE MASSOUDA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. N/A				17. INFORMANT ADDRESS DR. BENJAMIN MASSOUDA 10 COREYDALE COURT DOWNSVIEW, ONTARIO, CANADA, (M3H4T2)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9503 IMMEDIATE CAUSE (a) Acute imipramine and amitryptiline intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11/19/79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject ingested overdose					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) motel				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Ramada Inn Rt. 28 Rockville, Montg. Co., Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Virginia L. Dolan				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 11/21/79	
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 11/23/79		23c. NAME OF CEMETERY OR CREMATORY LINCOLN PARK				23d. LOCATION CITY OR TOWN COUNTY STATE WARWICK, RHODE ISLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS.				6010 REISTERSTOWN RD. ADDRESS BALTIMORE, MD. (21215)				25a. DATE REC'D. BY REGISTRAR NOV 28 1979				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

70

Office

Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR REGISTERAR		7 9 3 1 3 1 5											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Anna		Nina		Lewis				12-20-79		6:25 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
Female		White		May 1, 1899		80 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Ontario, Canada		USA				Montgomery MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington Adventist Hosp.						Housewife		-----			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Montgomery		Sil Spg.				8500 N. H. Ave.					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Albert Ratney				Sarah Smelnitsky									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				133-12-0325D		Raymond Lewis; 12017 Aintree Lane Reston, Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized atherosclerosis</u>										2 mo.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										3 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Urinary Tract Infection</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>10/14</u> , 19 <u>79</u> , to <u>12/20</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/19</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
<u>Keith M. Lindgren</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12/20/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
KEITH M. LINDGREN				7600 Carroll Ave., Takoma Park, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		12-21-79		G. W. Cemetery		Hyattsville, Pr. Geo, Md							
24. FUNERAL DIRECTOR NAME				24b. ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
Danzansky-Goldberg Chapels				1170 Rockville Pike Rockville, Md.				DEC 26 1979				<u>Keith M. Lindgren</u>	

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

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10/10/70

10/10/70

10/10/70

(R 4)
(S 3)
(D 2)

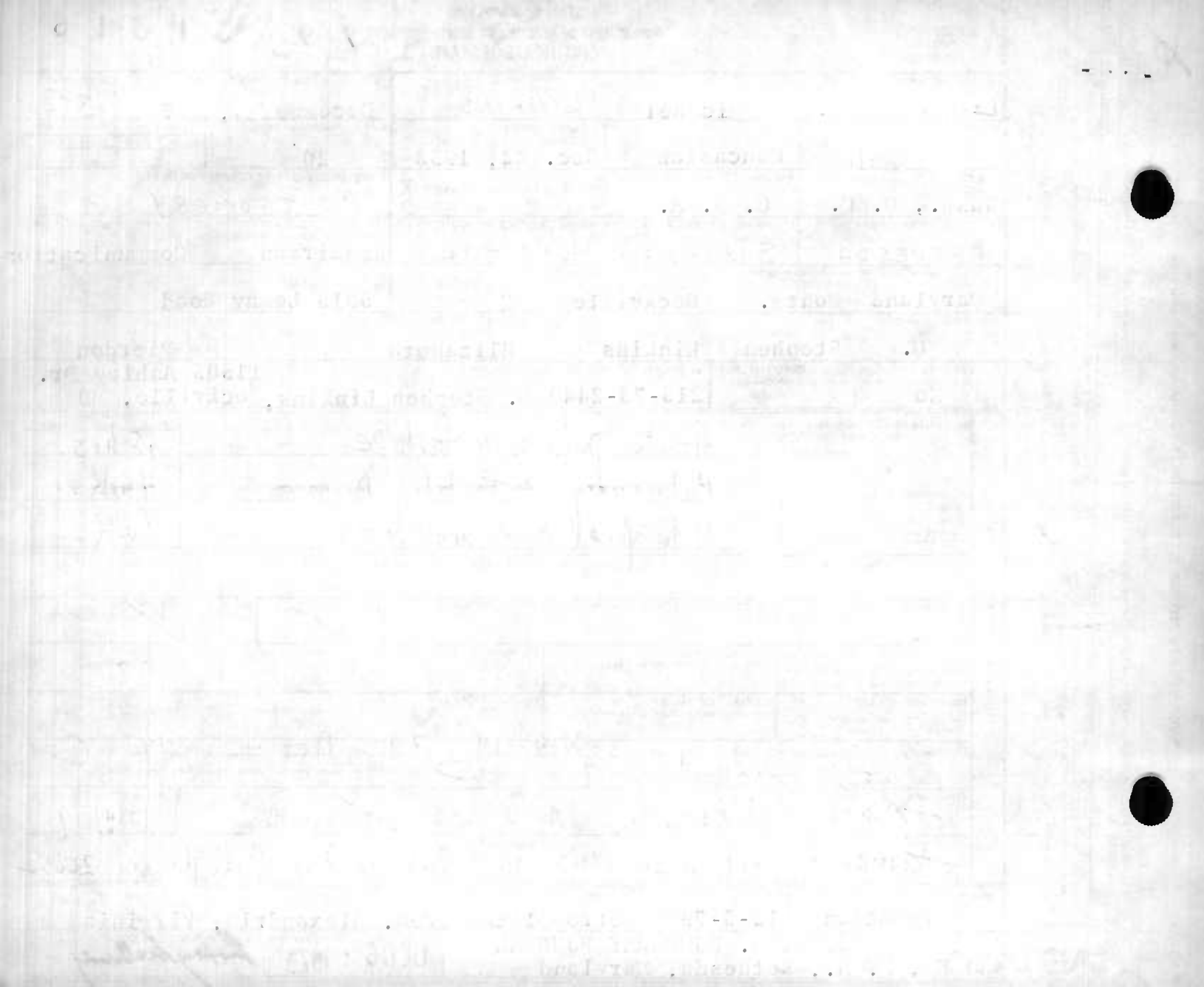
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					7 9 3 1 3 1 6	
1- FOR STATE REGISTRAR			CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR
L. Michael LINKINS						December 4, 1979
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR 3:29 AM	
Male	Caucasian	Dec. 22, 1958	20 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Wash., D. C.	U. S. A.			MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA	SUBURBAN HOSPITAL		Repairman		Communication	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Maryland	Montg.	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5913 Lemay Road		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
G. Stephen Linkins			Elizabeth Pierdon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		
No		218-76-2440		11505 Ashley Dr. G. Stephen Linkins, Rockville, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 1990 Acute Pulmonary Failure						48 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Metastatic Disease						4 wks.
DUE TO, OR AS A CONSEQUENCE OF (c) Wide-spread carcinomatosis						4 wks.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19, 1979, to Dec. 4, 1979, that (I) (we) last saw the deceased alive on Dec. 4, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE James E. Wilson, Jr.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Wilson, Jr. M.D.		22e. ADDRESS 11125 Rockville Pike, Rockville, Md. 20852				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		12-5-79	Metropolitan Crem.		Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]

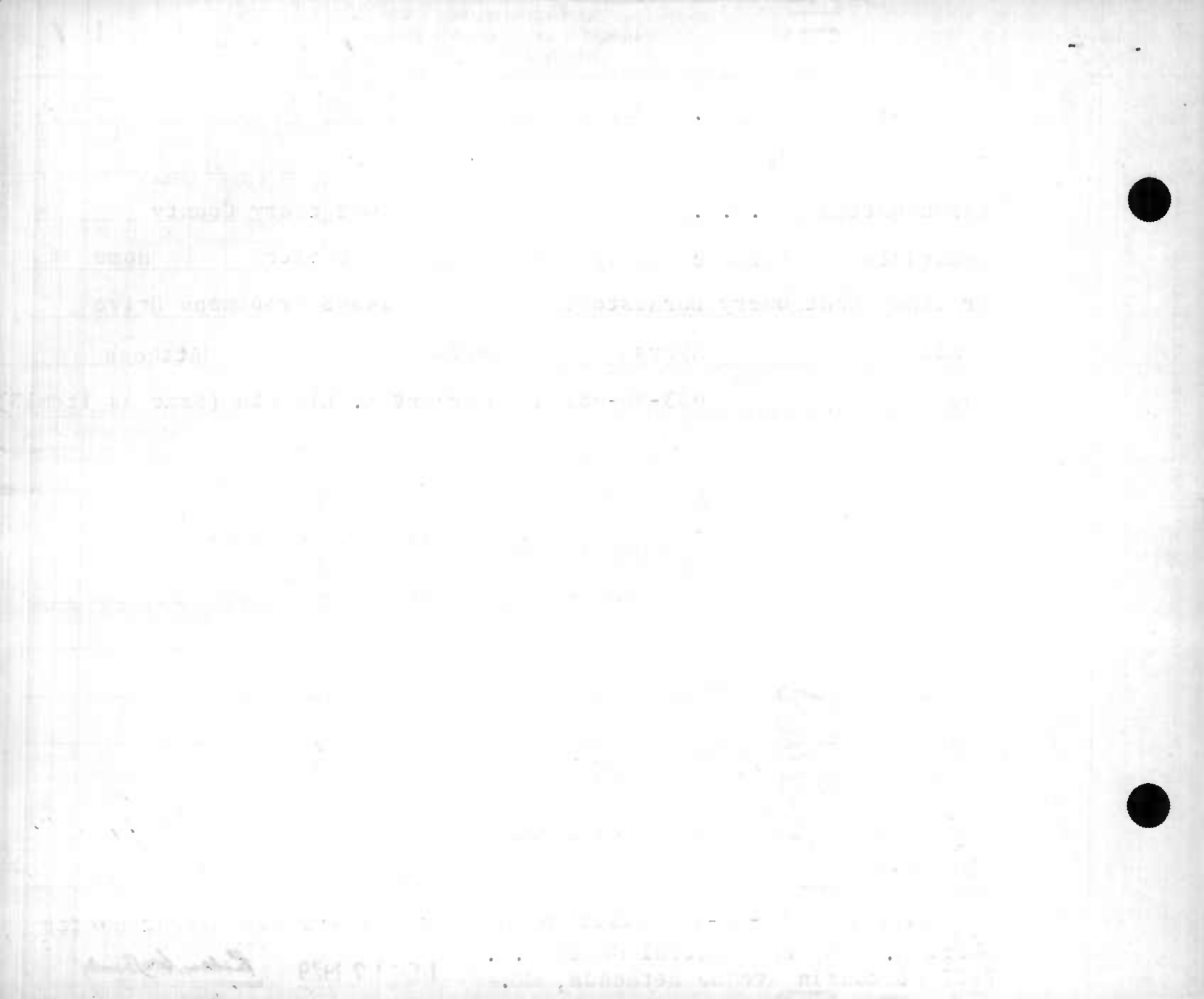


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 31317			
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR		
Marion A. Lippold						12/13/1979					17:00 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. YEARS (LAST BIRTHDAY)		8. IF UNDER 1 YEAR		9. IF UNDER 24 HRS	
Female		Caucasian		May 17, 1897		82		YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Massachusetts		U.S.A.				Montgomery County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Potomac Valley Nursing Home								Homemaker		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14505 Brookmead Drive	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST										FIRST MIDDLE LAST			
Eli Eyers										Martha Matthews			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS	
No										033-09-6810A		Herbert R. Lippold (Same As Item 13)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRYTHMIA</u> <u>4149</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>OLD CEREBROVASCULAR ACCIDENT</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 13, 1979</u> to <u>Dec 13, 1979</u> , that (I) (we) last saw the deceased alive on <u>Dec 13, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE		22c. DATE SIGNED	
										DEGREE			
										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS			
ROBERT C. DADDARIO										5413 CEDAR LAKE BETHESDA MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. REGISTRAR'S SIGNATURE					
Burial		12-17-79		Bellevue Cemetery		Lawrence Massachusetts							
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes P.A. 7557 Wisconsin Avenue Bethesda, MD.										DEC 17 1979		Robert A. Pumphrey	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILE. IF THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 79 31318					
1- STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT) PAUL HENRY LOEFFLER						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 22 1979						2b. HOUR 7:18a					
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 05 25		6. AGE (IN YEARS) LAST BIRTHDAY 54 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12 22 1979		2d. HOUR 7:18a			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Mon t gomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED VETERAN				12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9734 51st Ave.									
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM LOEFFLER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA HUEBLER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT ADDRESS Dorothy L. Loeffler Same as #13 (Wife)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Inf 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Chronic Myocardial Dis 4yr DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE John S Rogers M.D.										TITLE (SPECIFY) Doc			MEDICAL EXAMINER			DATE SIGNED Dec 22/1979	
EXAMINER'S NAME (TYPE OR PRINT) John S Rogers				ADDRESS Silver Springs, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Md Veterans Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Pro Georges Md.							
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland										25a. DATE REC'D. BY REGISTRAR DEC 31 1979			25b. REGISTRAR'S SIGNATURE Robert McBrady				

[illegible]

1978 12 28 2570

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

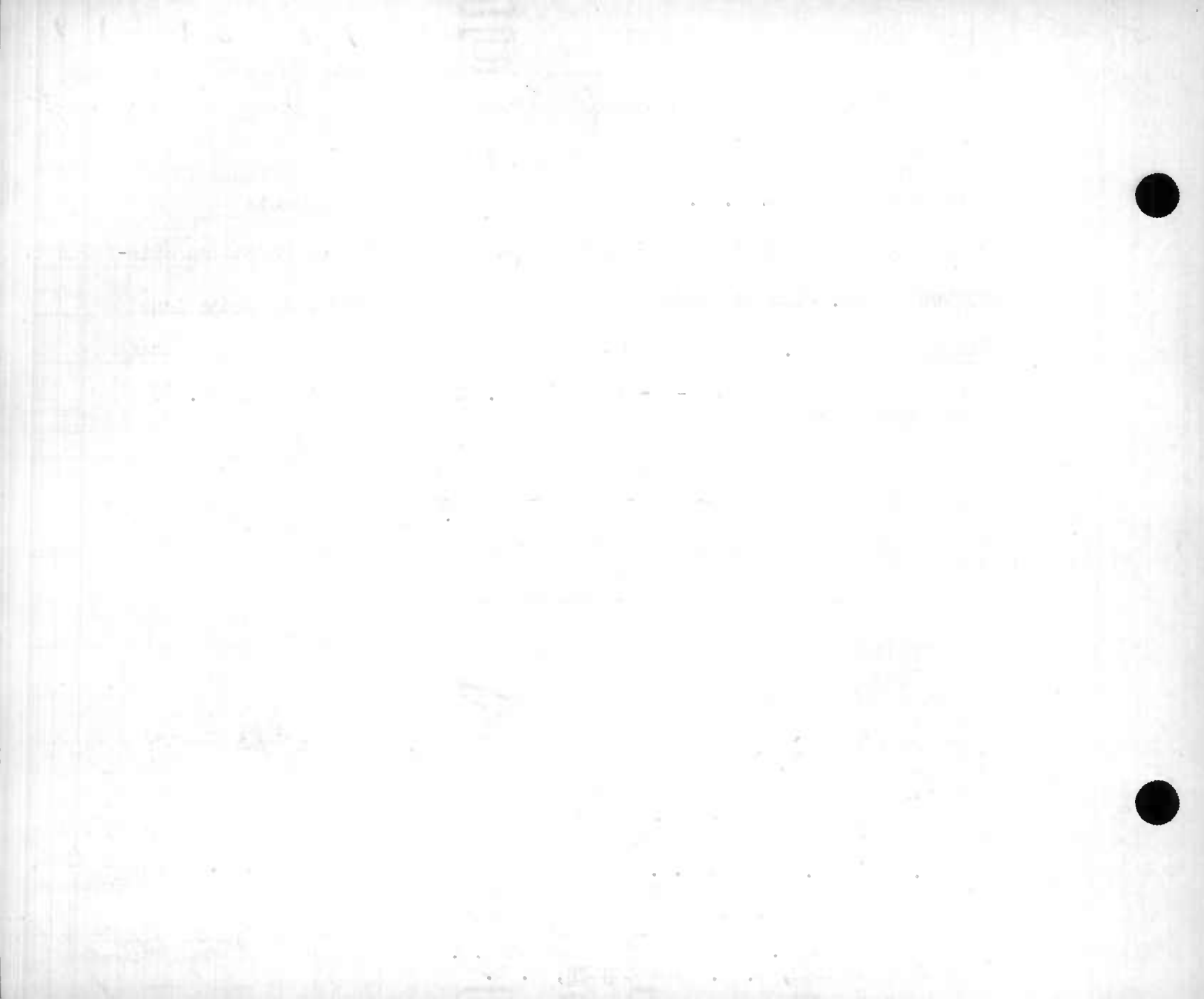
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 79 31319							
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Marilyn Diamond Loeser				2a DATE OF DEATH MONTH DAY YEAR December 15 1979		2b HOUR 12:30 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 26, 1932		6 AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		7 IF UNDER 1 YEAR IF UNDER 72 HRS MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Interior Decorator		12b KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
13a STATE 13b COUNTY 13c CITY OR TOWN 13d INSIDE CITY LIMITS? 13e STREET ADDRESS Maryland Pr. Georges Bowie YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 12049 Twin Cedar Lane									
14 FATHER'S NAME FIRST MIDDLE LAST Samuel J. Diamond					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Brill				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 470-30-6983		17 INFORMANT Lee M. Loeser			ADDRESS Same as No. 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
MEDICAL CERTIFICATION									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 12/30 1979 to 12/15 1979, that (I) (we) last saw the deceased alive on 12/15 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death)									
22b SIGNATURE DR. LEWIS H. DENNIS, M.D.				DEGREE M.D.				22c DATE SIGNED 12/15/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DR. LEWIS H. DENNIS, M.D.				22e ADDRESS 831 UNIVERSITY BOULEVARD, E. SILVER SPRING, MARYLAND					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12/17/1979		23c NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d LOCATION CITY OR TOWN COUNTY STATE Olney Montgomery Maryland			
24 FUNERAL DIRECTOR NAME Donald M. Stein				25a DATE REC'D. BY REGISTRAR DEC 19 1979				25b DATE REC'D. BY REGISTRAR DEC 19 1979	
232 Carroll Street, N. W. Washington, D. C.									

BP

DHMH-16 20M
(VRA 15, 4) 7/78



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME FOR FILE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 4 AND 5 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH														9 3 1 3 2 0 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth A. Loewenthal										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12.19.79		2b. HOUR 3:19 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1919		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 60 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12.19.79		2d. HOUR 3:19 AM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hsopital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7400 Honeywell Lane							
14. FATHER'S NAME FIRST MIDDLE LAST Max Weiner						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Rosenthal									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 131-05-3438		17. INFORMANT ADDRESS Bethesda, Md. Daniel Loewenthal; 7400 Honeywell Lane									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE John H. Ball				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER JOHN G. BALL, M.D.				DATE SIGNED Dec 19, 1979			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-24-79		23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodbridge, N.J.							
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR DEC 26 1979				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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Cleared with Medical Examiner

70

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 3 2 1	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Hilda R. Long</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12 18 79</i>			2b. HOUR <i>3 45</i> A.M.			
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 11 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Manager</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beauty Shop</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Maryland Montgomery Gaithersburg</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>Apt. 3 Walkers Choice</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Rogers</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Dosie M. Harris</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>-----</i>					16b. SOCIAL SECURITY NO. <i>579-22-1971</i>		17. INFORMANT (son) <i>11500 Viers Mill Road, Wheaton, Md, 20902</i> <i>Paul D. Brady</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrhythmia</i> <i>4241</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>aortic valve prosthesis malfunction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <i>about</i> <i>12-18</i> 19 <i>77</i> to <i>12-18</i> 19 <i>79</i> , that (1) (we) last saw the deceased alive on <i>12-18</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>James Brodsky</i> MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12-18-79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James Brodsky</i>					22e. ADDRESS <i>4701 Willard Ave Chevy Chase 20015</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>12-20-1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria Fairfax Va.</i>				
24. FUNERAL DIRECTOR <i>Walner E. Pumphrey, Inc.</i> <i>8434 Georgia Ave S S Md</i>					25a. DATE REC'D. BY REGISTRAR <i>DEC 26 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony McBrady</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Dr. John Ball, Medical Examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 3 2 2				
FOR 1. STATE REGISTRAR		7 9 3 1 3 2 2								REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Judith E Loyal								12/26/79					9 05 P	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
female		caucasian		3 11 40		39 YRS		MONTHS		DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH								
INDIANA		U.S.A.				Montgomery County MD								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda Md.		Suburban Hospital		PRESIDENT		LOYAL ENTERPRISES								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
MARYLAND		MONTGOMERY		POTOMAC		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8415 VICTORY LANE						
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME												
WM. E. WILLIAMS		MARY O'KEEFE												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS								
NO		Not Available		THOMAS J. LOYAL		(SAME AS 13e)								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Cerebral Anoxia		Arteriosclerotic Heart Disease		2 mo								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Juvenile Rheumatoid Arthritis, Congestive Heart Failure												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Jan 1975, to Dec 26, 1979, that (I) met saw the deceased alive on Dec 26, 1979, and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) did view the body after death.		22b. SIGNATURE W. H. KILLAX MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec 27 1979								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
W. H. KILLAX		8218 Wisconsin Ave Bethesda												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE								
BURIAL		12-31-79		HOLY CROSS CEMETERY		INDIANAPOLIS INDIANA								
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
ROBERT A. PUMPHREY FUNERAL HOMES P/A		ROCKVILLE MD.		JAN 2 1980										

RECEIVED BY THE DIRECTOR, 11 FEB 1958

UNITED STATES

12-21-57

JOHN C. ROYAL, JR.

INDIANAPOLIS

INDIANA

JOHN A. ROYAL, JR.

ROCKVILLE

Not Available THOMAS J. ROYAL (AGE 42)

O'NEILL

MARY

WILLIAM

E.

W.

MARYLAND

MONTGOMERY

POWYAT

6-15 VICTORY LANE

Bedford No. 1 Suburban Hospital

PRESIDENT

ROYAL

INDIANA

U.S.A.

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CONGRESSIONAL

SENATE

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E

SENATE

10/2/57



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 3 2 3							
1. FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST ANNE			MIDDLE C.			LAST LUND			2a. DATE OF DEATH MONTH DAY YEAR 12-22-79			2b. HOUR 7:52a.m.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 6 28 04			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.								
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY AT HOME					
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			15. STREET ADDRESS 15310 Pine Orchard DR.					
14. FATHER'S NAME FIRST MIDDLE LAST JOHN HENRY GREVE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA STEINHAEUER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-60-4812			17. INFORMANT ADDRESS WENDELL L. LUND (HUSB.) SAME AS #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____																	
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from <u>12/18</u> 19 <u>79</u> to <u>12/22</u> 19 <u>79</u> , that (1) (we) lost <u>above</u> the deceased alive on <u>12/18</u> 19 <u>79</u> , and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.																	
22b. SIGNATURE <u>Ralph D. Seligmann</u> MD						22c. DATE SIGNED DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH D. SELIGMANN						22e. ADDRESS 8630 FENTON ST. SILVER SPRING MD 20910											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-26-79			23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.								
24. FUNERAL HOME OR PERSON NAME ADDRESS JOSEPH CAWLER'S SONS INC. 5139 WISC. AVE., H. W. WASH., D. C. 20018						25a. DATE REC'D. BY REGISTRAR DEC 28 1979								25b. REGISTRAR'S SIGNATURE <u>Porter McBrady</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31324	
1. DECEASED NAME FIRST MIDDLE LAST MR. ROBERT ELLSWORTH LUTTRELL										2a. DATE KNOWN OF DEATH MONTH DAY YEAR Dec 13 1979	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Sept 12 1950		6. AGE (IN YEARS) LAST BIRTHDAY 50 YRS.		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH AKOMA PARK				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heating & Air-Condition		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md			13b. COUNTY Mont.			13c. CITY OR TOWN Tak. Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Garnet Luttrell						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael Best					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WWII				16b. SOCIAL SECURITY NO. 577 32 6992				17. INFORMANT Evelyn Luttrell (Wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Rogers						TITLE (SPECIFY) M.D.			DATE SIGNED Dec 13 1979		
EXAMINER'S NAME (TYPE OR PRINT) John Rogers						ADDRESS 1919 Seminary Rd. S.S.Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/17/79		23c. NAME OF CEMETERY OR CREMATORY Maryland VA Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, PG Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.						ADDRESS 11800 N.H.Ave. S.S.Md.			25a. DATE REC'D. BY REGISTRAR DEC 19 1979		
									25b. REGISTRAR'S SIGNATURE History McBrine		



TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____
DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

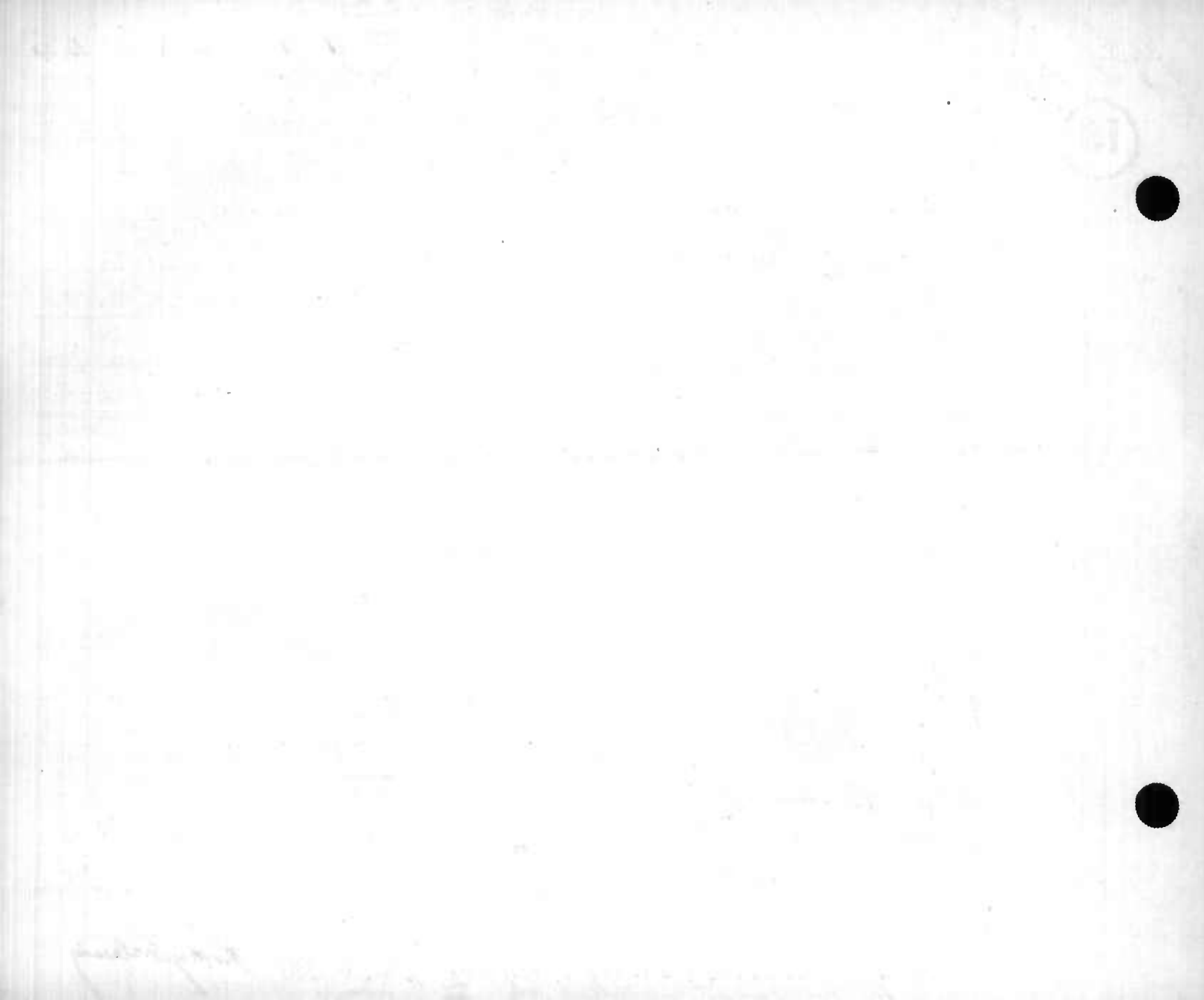
7 9 3 1 3 2 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Cedreus Lyons		2a. DATE OF DEATH MONTH DAY YEAR 12 9 79		2b. HOUR MIN 9:30	
3. SEX F	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 5 51		6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Pk, Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN D. C. none Wash.		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 1420 Van Buren St. N. W.	
14. FATHER'S NAME FIRST MIDDLE LAST Douglas C. Love		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leora Bouknight			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no N/A		16b. SOCIAL SECURITY NO. N/a		17. INFORMANT ADDRESS Leora Bouknight Love 1420 Van Buren NW	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Internal Hemorrhage 6954 DUE TO, OR AS A CONSEQUENCE OF: (b) Severe Sepsis DUE TO, OR AS A CONSEQUENCE OF: (c) Thrombocytopenia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) [this hospital] attended the deceased from 12-9-79 , 19____, to 12-9-79 , 19____, that (1) (we) lost saw the deceased alive on 12-9-79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If buried, did not view the body after death.)					
22b. SIGNATURE Charles L Franklin Jr		DEGREE MD		22c. DATE SIGNED 12-9-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles L Franklin Jr		22e. ADDRESS 11200 Lockwood Dr S. Her Spring Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) December 15, 79 Burial		23b. DATE December 15, 79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland		23e. NAME OF FUNERAL HOME Latney's Funeral Home		23f. DATE REC'D. BY REGISTRAR JAN 10 1980	

24. FUNERAL DIRECTOR NAME ADDRESS
Latney's Funeral Home 3831 Ga Ave NW Wash DC

25. DATE REC'D. BY REGISTRAR
JAN 10 1980

26. REGISTRAR'S SIGNATURE
Latney's Funeral Home



BP.

DHMM-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 3 2 6			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					MONTH DAY YEAR		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					2b. DATE OF DEATH					MONTH DAY YEAR		7b. HOUR	
ANNE GENEVA MAC-AFEE					DEC 15 79							0730A ^M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7c. MONTH		7d. DAY		7e. YEAR	
FEMALE		CAUC		10 JUNE 21		58							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
VIRGINIA		USA				BETHESDA							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
BETHESDA		NATIONAL NAVAL MED. CEN		Operator		C&P Telephone							
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
VIRGINIA		FAIRFAX		SPRINGFIELD		7207 EVANSTON RD							
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME											
VIVAL STANLEY BAGBY		FLORINE WATSON FRANKLIN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS							
NO		224-22-2467		DONALD W. MAC AFEE									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CLOACOGENIC CARCENOMA													
1541 DUE TO, OR AS A CONSEQUENCE OF (b) OF THE RECTUM													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
T. J. Spurling				15 DEC 79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
T. J. Spurling		National Medical Naval Center, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE			
Burial		12/18/79		Beulah Methodist Cem.		Ablene				Va.			
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Wayne J. Spurling		Demaine Funeral Home Alexandria, Va. 22314		4 DEC 20 1979									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 22 is marked, or if there is any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) GRACE N. MACKIN		2a. DATE OF DEATH MONTH December DAY 22 , YEAR 1979		2b. HOUR 11:30 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 18 YEAR 18	
6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		8. CITIZEN OF WHAT COUNTRY? U. S. A.	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland COUNTY Montgomery CITY OR TOWN Potomac	
14. FATHER'S NAME FIRST Gabriel MIDDLE Nilsen LAST Haugen		15. MOTHER'S MAIDEN NAME FIRST Inga MIDDLE Haugen LAST Haugen		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW II	
16b. SOCIAL SECURITY NO. 559-30-4088		17. INFORMANT Thomas W. Mackin, Same as 13		18. ADDRESS 10645 Muirfield Dr.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Damage - Respiratory and Subarachnoid Hemorrhage and Cerebral Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Subarachnoid Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Aneurysm APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 430 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hydromyelia					
19a. DATE OF OPERATION 12/24		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydromyelia		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 12/24 , 19 79 , to 12/22 , 19 79 , that (I) (we) lost saw the deceased alive on 12/22 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE B. J. Vossen, M.D. DEGREE M.D.	
22c. DATE SIGNED 12/22/79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. J. Vossen, M.D.		22e. ADDRESS 19,000 Falls Rd. Potomac, Md. 20854	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-24-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 31 1979	
25b. REGISTRAR'S SIGNATURE [Signature]					



James M. Smith

MAILED
Faintly visible text, possibly a letter or document header, including words like "MAILED", "Faintly visible text", and "James M. Smith".

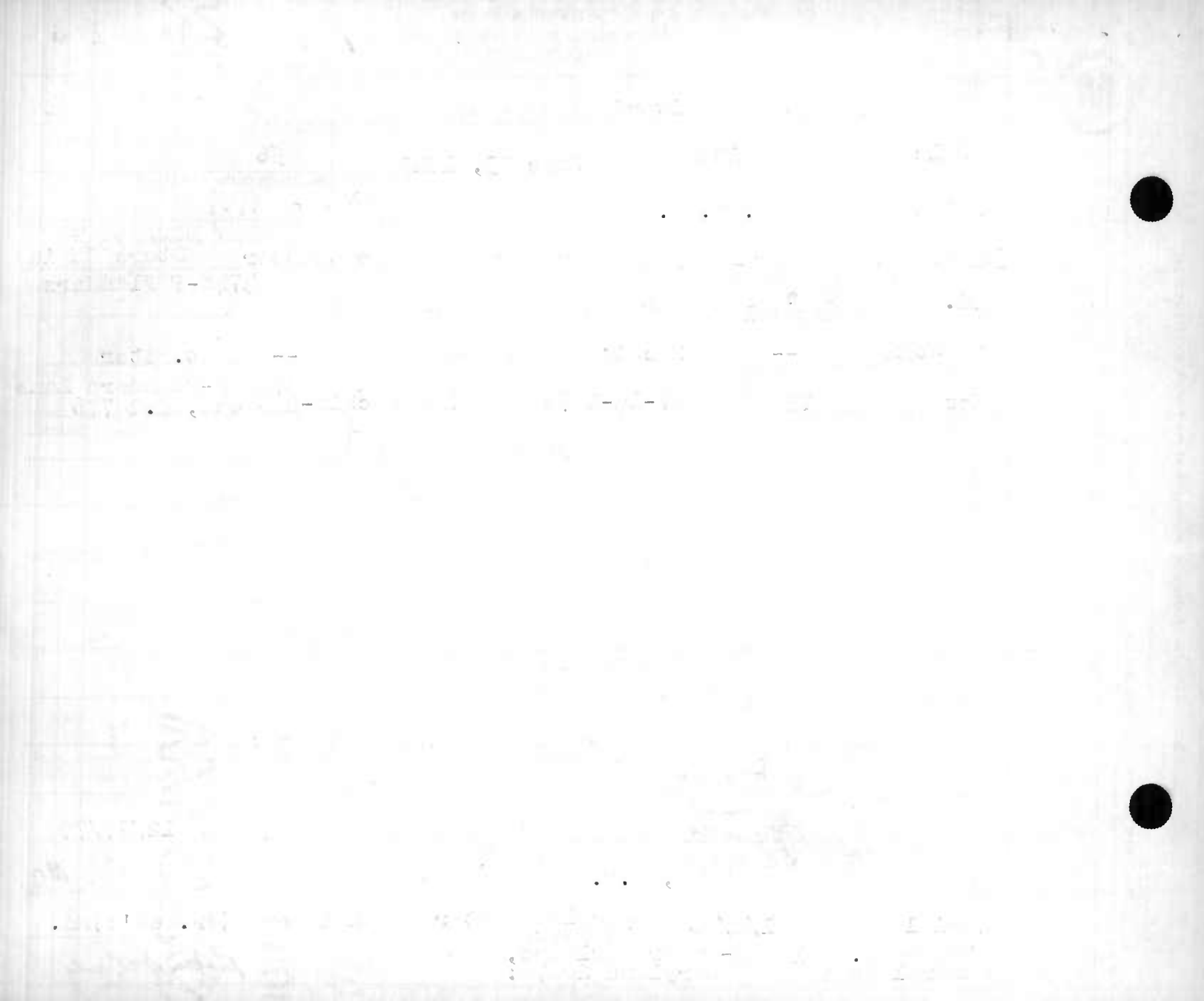
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 3 2 8			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
John Edward Mackin								12-29-79					500 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		June 23, 1923		56 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.	
Maine		U. S. A.				Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital		Meatcutter		Store Food Chain							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		Anne Arundel		Harwood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4748-F Flanders Lane					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John		Mackin		Alfreda		St. Peter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WWII		007-14-2679		Annalee Mackin-Harwood, Md. 20776							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. DUE TO, OR AS A CONSEQUENCE OF		22. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2050		cardiac arrest		Septic shock, anemia		acute myelogenous leukemia							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M.		19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from		19		to		19		that (I) (we) lost					
saw the deceased alive on		Dec 28		19		78		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
above, (I) (we) did; (I) did not view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
D J HAIDAK, M.D.		MD				12/29/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
D J HAIDAK, M.D.		6151 Belvidere Rd		Agassizville Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		1/2/80		Maryland Veterans Cemetery		Cheiltenham (Pr. Geo's) Md.							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Richard A. Coleman-Uppan Marlboro, Maryland 20870:		JAN 7 1980		R. J. McCreedy									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 2 9

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Lotta Madden			2a. DATE OF DEATH MONTH DAY YEAR December 6, 1979			2b. HOUR 6:50pm				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1884		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Wheaton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Singer		12b. KIND OF BUSINESS OR INDUSTRY Concert		
13a. STATE Virginia			13b. COUNTY Louisa		13c. CITY OR TOWN Louisa		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 16 Blueridge Shores	
14 FATHER'S NAME FIRST MIDDLE LAST Walter Ashby			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Lavercombe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 090-14-2373		17 INFORMANT ADDRESS Mary Madden McCann, Same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiorespiratory arrest 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HOSPITAL MEDICAL EXAMINERS)			20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from 4/1/78 to 12/6/79 and that (2) my opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.										
22b. SIGNATURE Myron L. Lenkin			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Myron L. Lenkin, M.D.			22e. ADDRESS 2309 Shorefield Rd. Wheaton, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/7/79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND						25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7931330	
1. FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) MAURICE MARGOLIS					2a. DATE OF DEATH MONTH DAY YEAR DEC 14 1979			2b. HOUR 11 30 PM			
3 SEX M		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 1 14 04		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? LISA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Wheaton Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nurs. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Govt. Emp. (Ret)		12b. KIND OF BUSINESS OR INDUSTRY GAO			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Dc		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Springs		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11700 Old Columbia Pike			
14 FATHER'S NAME FIRST MIDDLE LAST Solomon Leon MARGOLIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tauba unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 132-09-7360		17. INFORMANT ADDRESS Rockville, Md. Solomon L. Margolis; 11112 Arroyo Dr.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) disease with cerebro- DUE TO, OR AS A CONSEQUENCE OF (c) vascular insufficiency									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 11/21 1979 , to 12/14 1979 , that (I) (we) lost 2/14 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE B. N. ROSENBAUM, M.D.						DEGREE		22c. DATE SIGNED 12/15/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. N. ROSENBAUM						22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20795					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-16-79		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia					
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels;				ADDRESS Rockville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1- DECEASED NAME (TYPE OR PRINT) Vilma (NMI) Maris			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1979			2b. HOUR p 5:05 M			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 25 1889		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS 1	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Indiana		13b. COUNTY Lake		13c. CITY OR TOWN Merrillville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 700 West 79th	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Landa				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Not Available					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 313 07 1287		17. INFORMANT ADDRESS Martha Piper Drive 11132 Hunt Club Potomac, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/2 19 79 , to 12/24 19 79 , that (I) (we) lost saw the deceased alive on 11/30 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael Emmerby DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 12/24/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Newman, M.D.						22e. ADDRESS 6116 Wayside Dr. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/28/79		23c. NAME OF CEMETERY OR CREMATORY Calumet Park		23d. LOCATION CITY OR TOWN COUNTY STATE Merrillville Indiana		
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND						25a. DATE REC'D. BY REGISTRAR DEC 31 1979 25b. REGISTRAR'S SIGNATURE Arthur J. McBrady			

For (W-1) ...

Landmark

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University

University of Tennessee

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, FILL IN
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST.,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31332	
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Marilyn Ruth Maxwell		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR Dec 10 1979		7b. HOUR OF ESTI- MATED DEATH 6:58 AM	
3. SEX F		4. RACE Bk		5. DATE OF BIRTH MONTH DAY YEAR Oct 11 1929		6. AGE IN YEARS LAST BIRTHDAY 50		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		7c. DATE PRONOUNCED DEAD Dec 10 1979		7d. HOUR 6:58 AM	
10. CITY OR TOWN OF DEATH Tak Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Advent Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY None					
13a. STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Sil Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9527 Lawnsberry Ter			
14. FATHER'S NAME Boast Stroman		15. MOTHER'S MAIDEN NAME Liza Edwards		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		16c. UNKNOWN		17. DECEASED'S NAME George W. Maxwell (Husband) Md 9527 Lawnsberry Ter, Silver Springs	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> 4291 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis. yrs</u> (c) <u>None</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>											
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Charles Franklin</u>		TITLE (SPECIFY) M.D. <u>Dep.</u> MEDICAL EXAMINER		DATE Dec 19 1979							
EXAMINER'S NAME (TYPE OR PRINT) Charles Franklin MD		ADDRESS 7600 Carroll Ave, Takoma Pk, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, PGC, Maryland					
24. FUNERAL DIRECTOR NAME Modern Funeral Home		ADDRESS 3821-14th St, N.W. Wash, D.C.		25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

1951

CONFIDENTIAL

MEMORANDUM FOR THE RECORD

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San Francisco

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San Francisco

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LIBRARY OF THE UNIVERSITY OF CALIFORNIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 9 3 1 3 3 4 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alma M. McDowell			2a. DATE OF DEATH MONTH DAY YEAR 12 24 1979				2b. HOUR 10:45A		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10 5 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 415 MacArthur Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY dry cleaning	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 415 MacArthur Drive				
14. FATHER'S NAME FIRST MIDDLE LAST Robert McDowell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Cole						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 278 03 8935		17. INFORMANT ADDRESS Alice Copley same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic hypertensive heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 20 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 12/19 , 19 79 , to 12/24 , 19 79 , that (I) (we) lost saw the deceased alive on 12/19 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE W. J. Hall			22c. PHYSICIAN'S NAME (TYPE OR PRINT) William G. Hall					22d. ADDRESS 615 W. Montgomery Ave. Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/27/79		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland		
24. FUNERAL DIRECTOR NAME Iyson Wheeler Funeral Home, Inc. ADDRESS 1331 Rockville Pike Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE History McCreedy		

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 3 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLENN A. E. MCGRATH			2a. DATE OF DEATH MONTH DAY YEAR 12 4 79			2b. HOUR 9 35 A.M.			
3. SEX F		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 1 26 15		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUBURBAN HOSPITAL) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LAST YEAR) Public School		12b. KIND OF BUSINESS OR INDUSTRY	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE N.Y.			13c. COUNTY Westchester			13d. CITY OR TOWN Ardsley			13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13f. STREET ADDRESS 34 Lincoln Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Montwaaver Freeman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lora Lyda			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 291-16-6070			17. INFORMANT ADDRESS Tom Roudabush, 16 Santa Lane, Coral Gables, Fla.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>intestinal obstruction perforation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48h 6 mos.	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>COPD</u>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from <u>10</u> <u>12/1</u> 19 <u>79</u> , to <u>12</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.				22b. SIGNATURE <u>Stephen L. Schechter</u> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-4-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen L. Schechter MD</u>				22e. ADDRESS <u>8218 Wisconsin Ave #14, Bethesda Md 20814</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>12/6/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Cemetery Alexandria Fairfax Virginia</u>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <u>Robert A. Humphrey Funeral Homes</u>				ADDRESS <u>814 Rockville Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 12 1979</u>	
				25b. REGISTRAR'S SIGNATURE <u>Jeffrey McCreedy</u>			

Released by Dr. John Ball, Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked (b) (c), 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

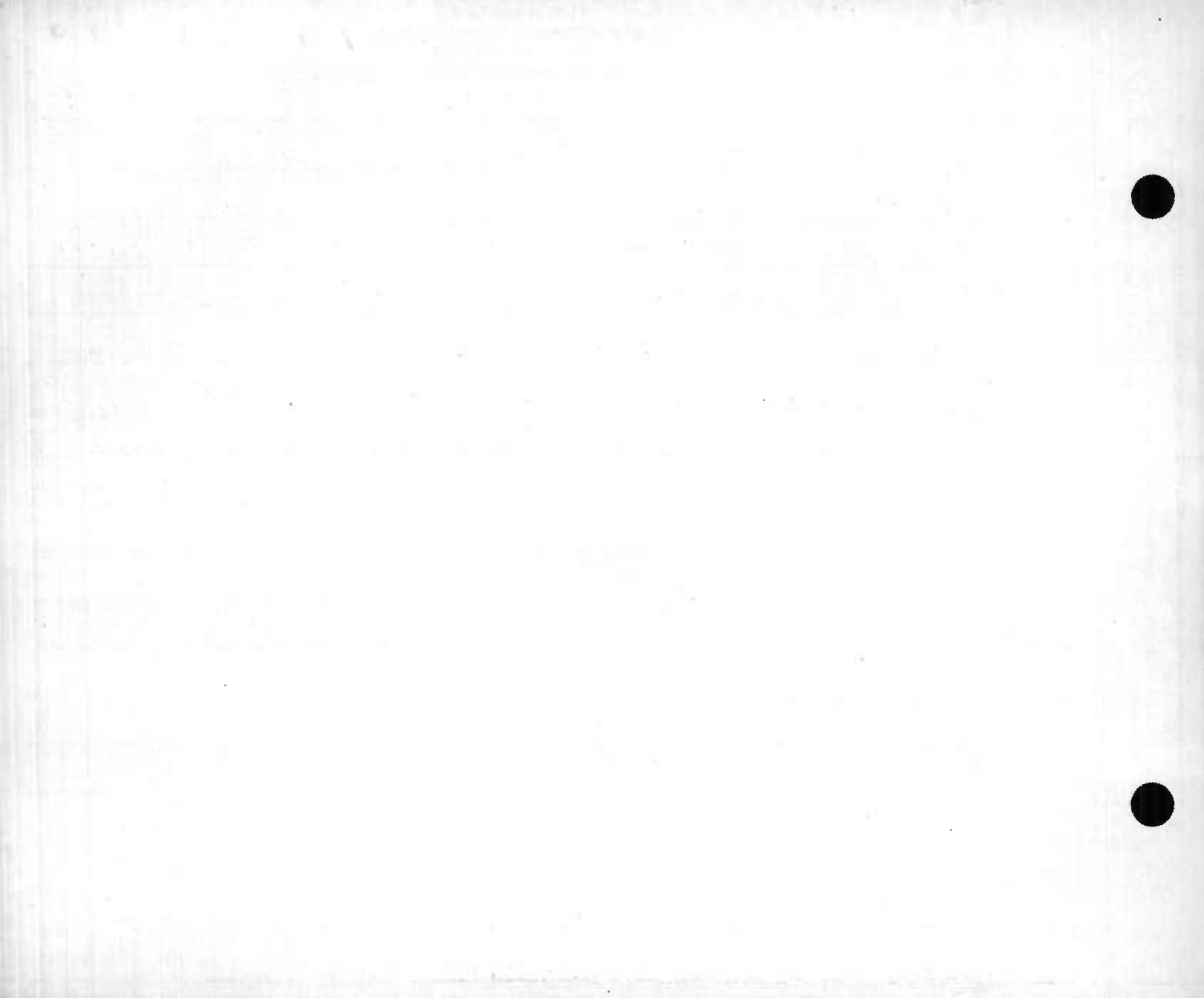
Released by Dr. John Ball, Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 3 1 3 3 6	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
SARAH		DEC 19 1979		11:10 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	July 16, 1892	87 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	USA		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital	Bookkeeper (Ret.)	Clothing		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Maryland		Montgomery	Sil Spg.	9205 Watson Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
Nathaniel		Muriel		Kensington, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		229-34-6496		Herbert Ziger; 9714 Hill Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Arteriosclerosis</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> 20 years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>January 1972</u> to <u>December 1979</u> , that (I) (we) lost the deceased alive on <u>December 19, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Blaine H. Eig</u>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>December 19, 1979</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			
BLAINE H. EIG		9901 Denham Ave. Bethesda, Md 20802			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12-21-79		Nat'l. Mem. Park	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Falls Church, Virginia					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Danzansky-Goldberg Chapels;		Rockville, Md		DEC 26 1979	
				25b. REGISTRAR'S SIGNATURE <u>Robert H. ...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Mental-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79 31337	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		a.	
		Oscar - Menis (Dr.)				December 13, '79		12:15		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		Caucasian		Jan. 6 1913		66 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Poland		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Gaithersburg		13113 Chestnut Oak Drive		Analytical Chemist		N.B.S.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md.		Montgomery		Gaithersburg						13113 Chestnut Oak Drive	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Joseph - Menis		Rose S. Saltpietre									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
No		0092-14-7049		Mrs. Ellen V. Menis		13113 Chestnut Oak Dr.					
				Gaithersburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
410-		Acute Myocardial Infarction		Arteriosclerotic Heart Disease				5 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.		CONGESTIVE HEART FAILURE due to ASYMMETRIC SEPTAL HYPERTROPHY									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from 1974 to 1979, that (I) (we) saw the deceased alive on 9 DEC 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED							
Forest K. Harris, M.D.		800 New Hampshire Ave., Washington, D.C.		14 DEC 79							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		12/14/79		Lee's Crematory		Washington D. C.					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Gartner-Sandison F. H. Gaithersburg, Md. 20760		DEC 17 1979		L. H. Harris							



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31338

1. FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE KNOWN OF DEATH		21. HOUR	
Craig W. Mertz		12 16 1979		11:20 P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE IN YEARS	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
Male	White	Feb. 7, 1947	32 YRS.		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	10. MARRIED		11. NEVER MARRIED	
Pennsylvania	U.S.A.	WIDOWED		DIVORCED	
12. CITY OR TOWN OF DEATH	13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
Bethesda	Suburban Hospital	Graduate Student		Education	
16a. STATE	16b. COUNTY	16c. CITY OR TOWN	16d. INSIDE CITY LIMITS?	16e. STREET ADDRESS	
Maryland	Montgomery	Wheaton	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	2504 Lindell St.	
17. FATHER'S NAME	18. MOTHER'S MAIDEN NAME	19. INFORMANT			
William A. Mertz	Eloise D. Reynolds	Phyllis C. Mertz/Wife Same as 13			
20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	20b. SOCIAL SECURITY NO.	20c. ADDRESS			
Yes	Vietnam	192-36-7438			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Blunt injury to chest with laceration of heart					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	11 P.M. 12 16 1979	Driver of auto/fixed object impact			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
	street	Beach Drive Bethesda, Montgomery, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED			
Virginia L. Dolan	Assistant	12/18/79			
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS	111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Cremation	Dec 1979	Lee Crematory	Washington, D.C.		
24. FUNERAL DIRECTOR	25. COUNTY	26. REGISTRAR	27. REGISTRAR'S SIGNATURE		
Capitol Funeral Service	Fairfax, Virginia	DEC 20 1979			

July 1, 1964

Washington, D.C.

Dear Sir:

Enclosed

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 3 1 3 3 9 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Isabelle M. Michaelski					2a. DATE OF DEATH MONTH DAY YEAR Dec. 2, 1979			2b. HOUR 1:30 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec., 16, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Warsaw, Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Jelleff's	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Montgomery 13c. CITY OR TOWN Sil. Sp.					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 900 Arcola Ave		
14. FATHER'S NAME FIRST MIDDLE LAST Vitold Chlopicki					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda Servatowski				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Joseph V. Michaelski-son		ADDRESS 3611 So. Leisure World Blvd. Sil. Sp. Md. 20906			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 2503 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetic nephropathy, Anemia, arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>19 69</u> to <u>12-2</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-2</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M Snow MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M SNOW MD				22e. ADDRESS 9013 FLOWER AVE SILVER SPRING					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-4-79		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C. 20002 Md 20901			
24. FUNERAL DIRECTOR NAME Lee Funeral Home 300-4th St. N.E. Wash. D.C.				25a. DATE REC'D. BY REGISTRAR DEC 7 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

Operation 12-4-79 Lee's Promotion 12-4-79 1000

No

Home

149-20-8922

Joseph V. Michaelis - son of J. V. Michaelis
World Blvd. Bldg. No. 2000

Vitold Chelicki

Matilda Gervatowski

Ms.

Montgomery

Bldg. 30

X

900 Ancho Ave

Silver Spring Holy Cross Hospital

Ret. Salesperson Jeffrey's

Barrow, Iowa

USA

X

Montgomery

Female

White

Dec. 16, 1966

62

Dec. 2, 1979

1:30

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARGIE H. MILLS			2a. DATE OF DEATH MONTH 12- DAY 21- YEAR 79			2b. HOUR 10:30p			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 12- DAY 10- YEAR 02		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Mont. 13c. CITY OR TOWN Germantown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Frederick Road 19515			
14. FATHER'S NAME FIRST William MIDDLE E. LAST Howard				15. MOTHER'S MAIDEN NAME FIRST Mattie MIDDLE E. LAST Trail					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-03-3390		17. INFORMANT ADDRESS Charles I. Mills Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute left Cerebrovascular Accident 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Lymphoma, Immune thrombocytopenic purpura, Coma, aspiration pneumonia, CHF									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug , 19 79 , to 21 Dec , 19 79 , that (I) last last saw the deceased alive on 21 Dec , 19 79 , and that in (my) hour opinion death occurred on the date and hour and from the causes stated above. (I) viewed did not view the body after death.									
22b. SIGNATURE Donald E. Dillon MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 22 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon				22e. ADDRESS Prince Phillip Dr. Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 24, 1979		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Mont. Md.			
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 20760				25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE L. J. McBratney			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

100-100-100

100-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 4 1

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
JEAN		JEAN	K.	MINETTI	12	15	79		8:45 PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Caucasian		Jan. 21 1924		55		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
D.C.	U.S.A.				Montgomery MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (IFE))		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	Suburban Hospital				Homemaker		Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE					YES <input type="checkbox"/> NO <input type="checkbox"/>		5106 Brookeway Drive		
13b. COUNTY									
13c. CITY OR TOWN									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
William Patrick Kerr					Elizabeth Fraser				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		577-26-6333		G. Joseph Minetti, Husband. Same as item 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 431- Brain Death									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Intercerebral Hemorrhage									44 hr.
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 12/18/79, 1979 to Dec 15, 1979, that (I) (we) lost saw the deceased alive on Dec 15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Charles W. Humphreys, Jr.					22b. DATE SIGNED 12/15/79			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
					1712 Eye St., N.W. Wash., D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/19/1979		Gate of Heaven Cem		Silver Spring, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph Gawler & Sons Inc. 5130 Wisconsin Ave. Wash. D.C. N.W.					DEC 19 1979		[Signature]		



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Jan. 22 1924

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U.S.A.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

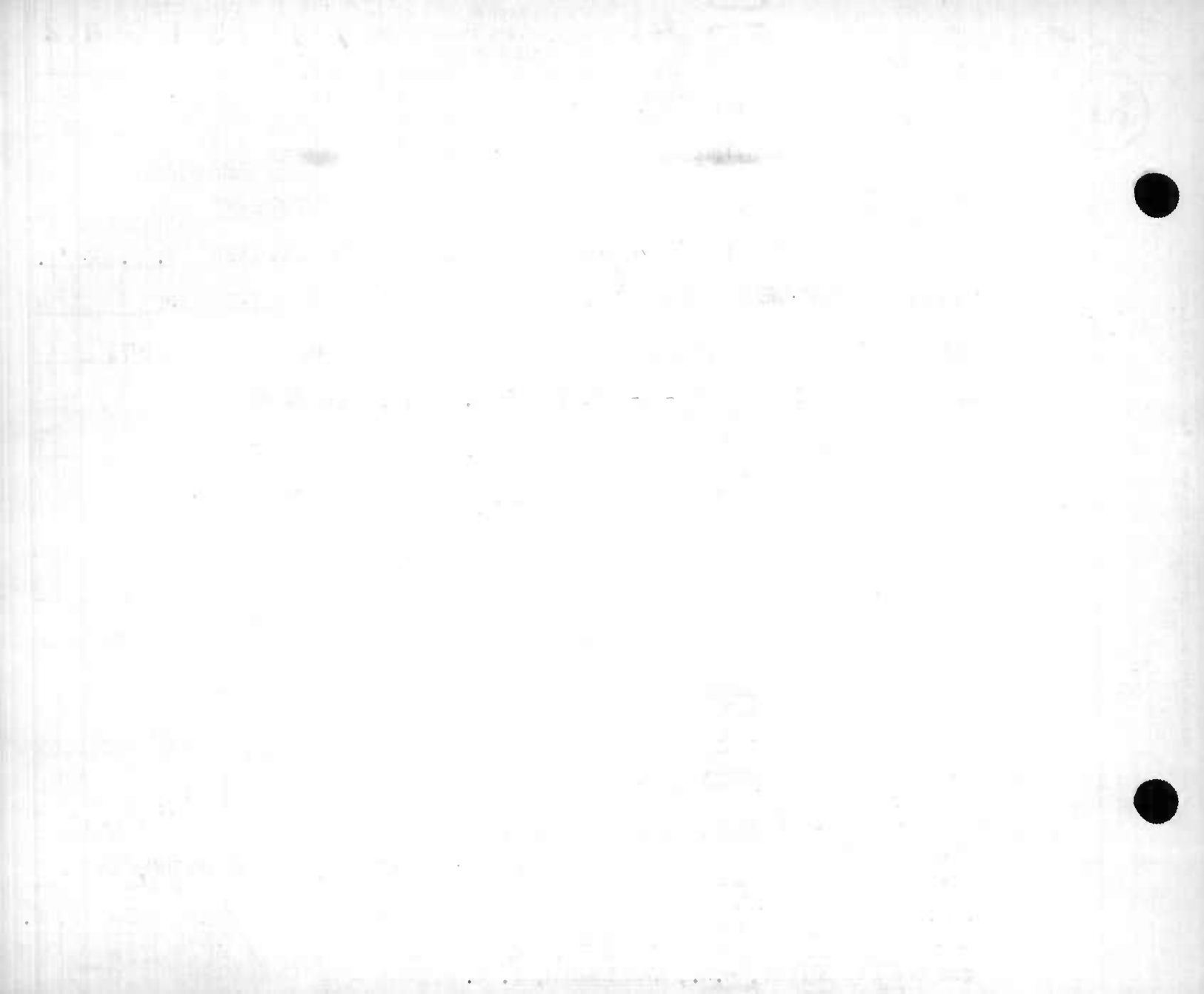
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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nathan LOUIS Mintz			2a. DATE OF DEATH MONTH DAY YEAR 12/3/79			2b. HOUR 7 ⁴⁰ P.M.	
3 SEX Male		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11/18/05		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PATENT EXAMINER		12b. KIND OF BUSINESS OR INDUSTRY U. S. GOV'T.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. CITY OR TOWN MONTGOMERY		13c. STREET ADDRESS SILVER SPRING	
14 FATHER'S NAME FIRST MIDDLE LAST MORRIS MINTZ				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA LIEBE MINTZ			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT ADDRESS ROSE G. MINTZ, same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4330 Progressive Brain Stem CVA. DUE TO, OR AS A CONSEQUENCE OF (b) Progressive Basal Artery Thrombosis. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. GARRIS				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. GARRIS				22e. ADDRESS 1109 SPRING STREET, SILVER SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/5/1979		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ADELPHI PRINCE GEORGES, MD.	
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR DEC 10 1979		25b. REGISTRAR'S SIGNATURE Dorothy McCready	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 3 4 3			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John R. Mockabee										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12/19 19 79		2b. HOUR OF ESTI- MATED DEATH <input checked="" type="checkbox"/> 12/19 19 79 A. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 30, 1946		6. AGE (IN YEARS) LAST BIRTHDAY 33 YRS.		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12/20 19 79 P. M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Kensington				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11108 Middlevale Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY school			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11108 Middlevale Road					
14. FATHER'S NAME FIRST MIDDLE LAST Fred A. Mockabee, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl E. Hale									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 212 52 0494		17. INFORMANT Fred A. Mockabee, Jr. Wheaton, Md.				ADDRESS 2322 Blueridge Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes mellitus.</u> 3500 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Hypothermia</u>													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 12/21/79					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/79		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852						25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>					

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
FOR 1- STATE REGISTRAR		REG. NO. 31344									
4. DECEASED NAME (TYPE OR PRINT)		THOMAS J MOLSKY						2a. DATE KNOWN OF DEATH		2b. DATE OF ESTI- MATED	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Penna.		U.S.A.		WIDOWED		DIVORCED		MONTGOMERY		School Teacher	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
OLNEY		MONTGOMERY GENERAL HOSPITAL						School Teacher			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md		Mont.		Damascus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10757 Middleboro Dr.			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
Jack Stanley Molsky						Sophia Zimowski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes						Korean		163-26-7115 Patricia A. Molsky, Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
None											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
None										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
								STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE						TITLE (SPECIFY)			DATE SIGNED		
John S. Rogers, M.D.						M.D. Dep			Dec 15/19 79		
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS					
John S. Rogers, M.D.						Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Burial				Dec. 18, 1979		Mt. Olivet				Frederick, Frederick, Md.	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME Olin L. Molesworth, ADDRESS Damascus, Md.						DEC 19 1979			Frederick McBrady		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROSE C. MONET			2a. DATE OF DEATH MONTH December DAY 1 YEAR 1979			2b. HOUR 5:45 P.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH Jan. DAY 6 YEAR 1895		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE MD		13b. COUNTY 13		13c. CITY OR TOWN Wash., DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1300 Iris Street, N.W.	
14 FATHER'S NAME FIRST John MIDDLE E. LAST McDonald		15 MOTHER'S MAIDEN NAME FIRST Rosanna MIDDLE LAST Griffin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) none		17 INFORMANT ADDRESS Ellen C. McDonald-Sister-(same as 13e)					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STATUS POST CRANIOTOMY FOR MENINGEAL 2252 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) RESIDUAL C.U.A. DUE TO, OR AS A CONSEQUENCE OF (c) ASTROSTOMY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YRS 3 YRS 2 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/18/79 , 19 79 , to 12-1- , 19 79 , that (I) (we) last saw the deceased alive on 11/29/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Lawrence Thomas M.D.		DEGREE ATTENDING PHYSICIAN		MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/2/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 11801 ROCKVILLE PIKE		22e. ADDRESS LAWRENCE J. THOMAS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-4-1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN Sil. Spring Montg. Md. COUNTY STATE			
24 FUNERAL DIRECTOR Warner E. Pumphrey		24b. ADDRESS 8434 Ga. Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR DEC 4 1979		25b. REGISTRAR'S SIGNATURE Arthur McQuay			

BP

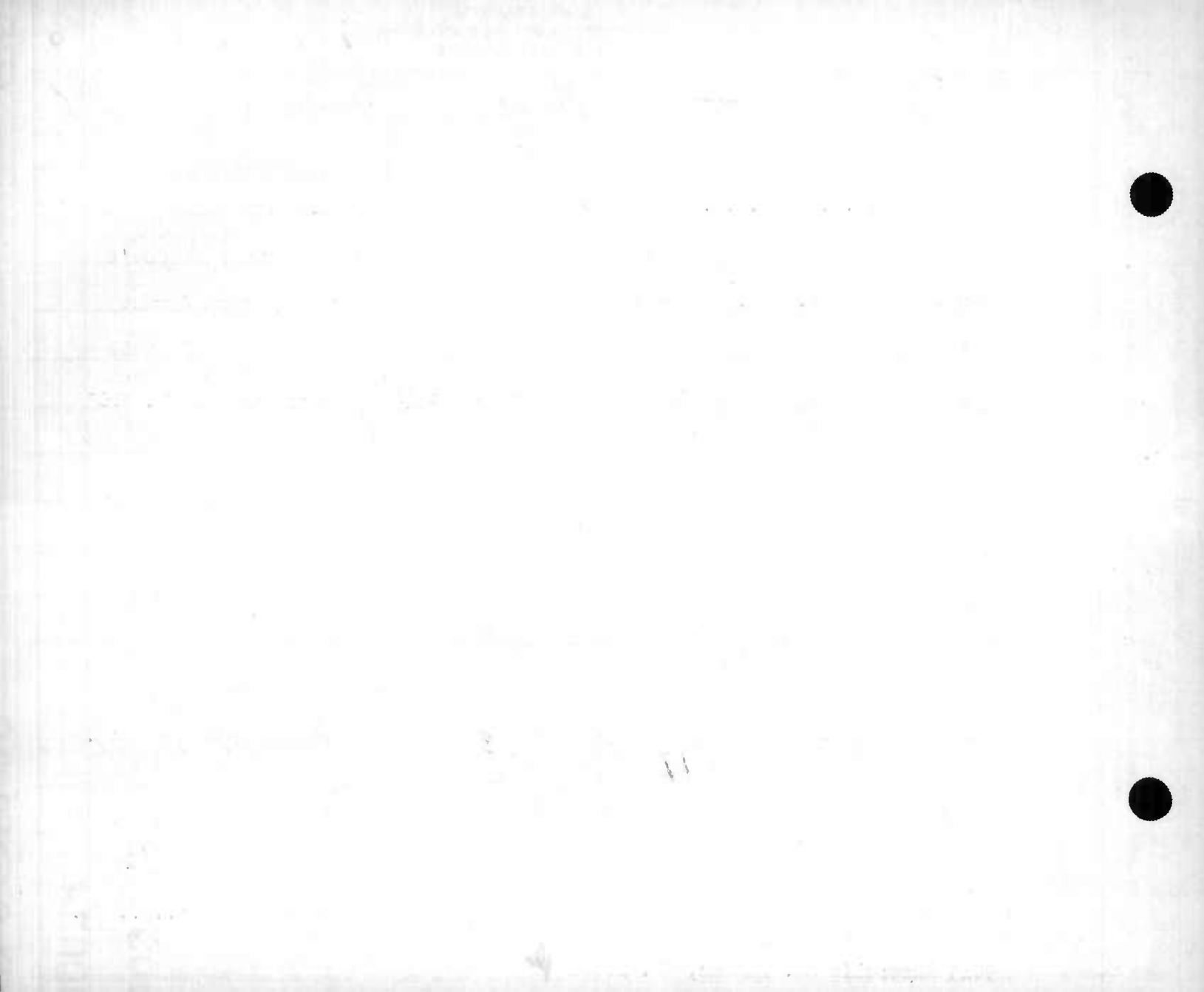


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 3 4 6
1. FOR STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Dorothy Marion Moore			2a. DATE OF DEATH December 22, 1979			2b. HOUR 2:00 PM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Jan 1, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coast Guard		12b. KIND OF BUSINESS OR INDUSTRY Gov't		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. CITY OR TOWN Pr. Geo.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9509 Tuckerman Street			
14. FATHER'S NAME Thomas			15. MOTHER'S MAIDEN NAME Boswell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. n/a		17. INFORMANT Dorothy Vaughn		ADDRESS 3306 Royale Glen Avenue Davidsonville, Md. 21035			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Glioblastoma of Brain</u> 1919 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate Interval Between Onset and Death: <u>Months</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>November 18, 1979</u> to <u>December 23, 1979</u> , that (I) (we) last saw the deceased alive on <u>November 19, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>[Signature]</u>			DEGREE <u>[Signature]</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-23-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Beverly Ann H. H. H.			22e. ADDRESS 3720 Fanning Ave. New Md. 20755							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 27 DEC 79		23c. NAME OF CEMETERY OR CREMATORY Lakemont Memo Gdns		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville, A.A., Md.			
24. FUNERAL DIRECTOR NAME Robert G. Beall ADDRESS 9013 Annapolis Rd. Lanham, Md. 20801					25a. DATE REC'D. BY REGISTRAR JAN 4 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 3 1 3 4 7	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ADELAIDE TUTTLE MORGAN						2a. DATE OF DEATH MONTH DAY YEAR Dec 31-79		2b. HOUR 630P		M	
3 SEX F		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 6 98		6 AGE (IN YEARS LAST BIRTHDAY) 81		7 UNDER 1 YEAR MONTHS DAYS YRS		7 UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 820 BENEFIT STREET 20910						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY —	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3 QUINCY STREET 20015			
14 FATHER'S NAME FIRST MIDDLE LAST LEROY — TUTTLE						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA HUNTON HURD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-46-4305		17 INFORMANT ADDRESS LEROY MORGAN 25214 DEACHTERS ROAD CLARKSBURG MD 20734							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ?										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1hr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from now 19 78 to Dec 31 19 79 , that (I) (we) lost saw the deceased alive on Dec 26 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William D. Aud MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/31/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM D. AUD						22e. ADDRESS 9006 Colver Hill Rd, Silver Spring MD 20910					
23a. BURIAL, CREMATION (REMOVAL) (SPECIFY) Removal				23b. DATE Dec 31, 1979		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR JAN 9 1980		25b. REGISTRAR'S SIGNATURE Heating McBrady	

MEDICAL CERTIFICATION



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "University" and "Chicago" are faintly visible.]



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be detached for use at the funeral home. This page should be removed from the certificate. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, another traumatic event, the medical examiner must be notified at once.

cert. cleared by Dr. Rogers

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 3 4 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence Sinclair Moyer						2a. DATE OF DEATH MONTH DAY YEAR 12 26 79		2b. HOUR 7:52P			
1. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 9 93		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. GOVERNMENT		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland						13c. COUNTY MONTGOMERY		13d. CITY OR TOWN Takoma Park			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES SINCLAIR						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY McGONIGAL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 112-05-0886		17. INFORMANT SON		ADDRESS 413 LANARK WAY SILVER SPRING, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable MI & arrhythmia / pump failure DUE TO, OR AS A CONSEQUENCE OF (b) ASND + Arterio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) atypical Angina CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last 410 - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 5 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) type IV hyperlipoproteinemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (he/she) attended the deceased from 8/6/76 , 19 76 , to Dec 26 , 19 79 , that (he/she) lost saw the deceased alive on Dec 24 , 19 79 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death.											
22b. SIGNATURE Mark D Andrews				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark D Andrews				22e. ADDRESS TAKOMA PARK, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/29/79		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE Patricia McQuinn					
25c. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

14

СЛЕДЪ СЪСТАВЪ НА ДЪЛЪ КОСТА

Fluorinated 2,4-dinitrophenol

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

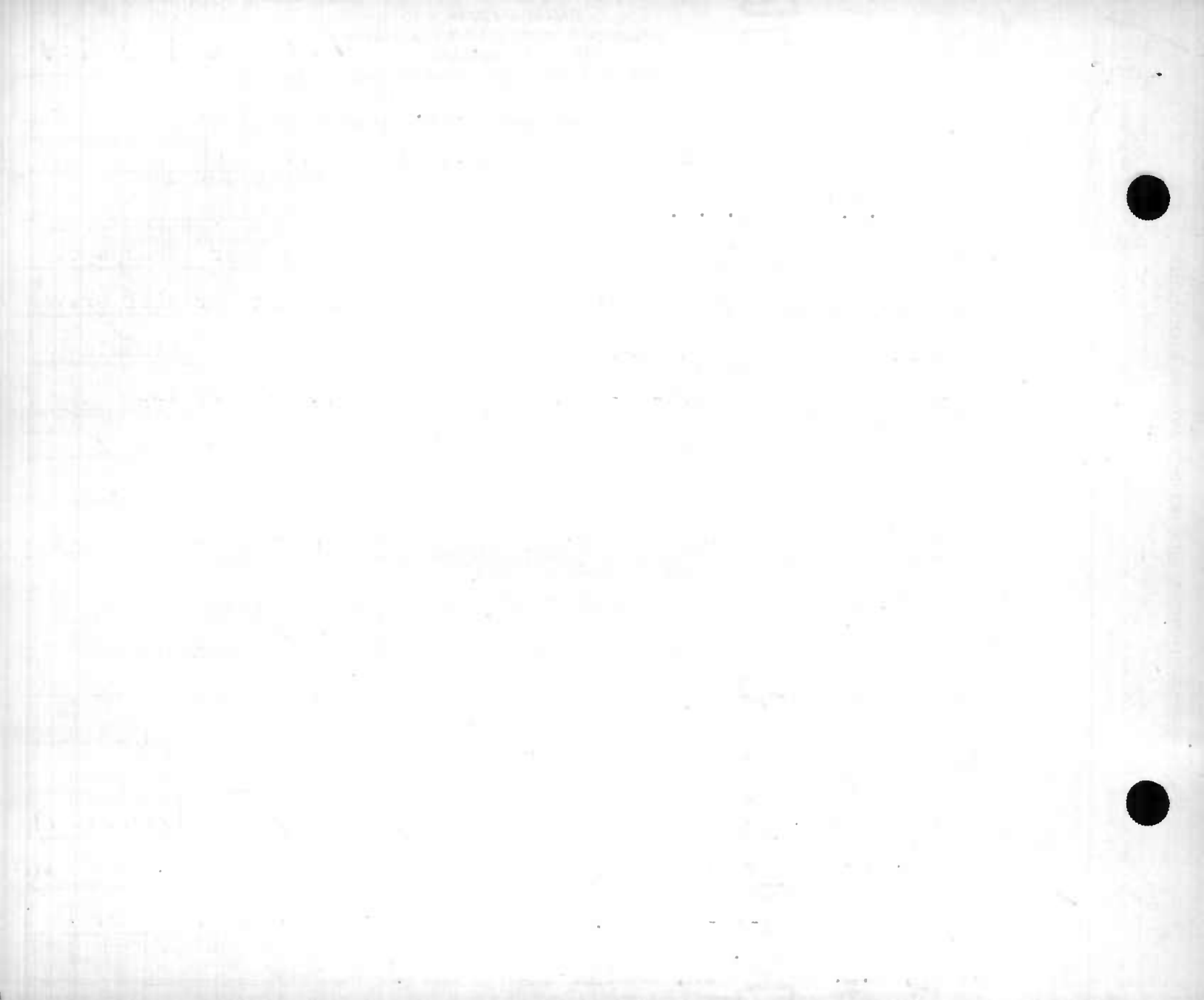
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 3 4 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John C. Mueller, Sr.					2a. DATE OF DEATH MONTH DAY YEAR 12 27 79				2b. HOUR 5 A M				
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 31, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.							
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Photographer		12b. KIND OF BUSINESS OR INDUSTRY Newspaper					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9316 East Parkhill Drive					
14 FATHER'S NAME FIRST MIDDLE LAST Conrad Mueller					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Liebold								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-10-2212		17 INFORMANT ADDRESS Bernice Mueller, Same as 13e									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 410- DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLECTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSIVE CARDIOVASCULAR DISEASE 16 yrs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 d.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 9/14 1963 to 12-27 1979, that (I) (we) last saw the deceased alive on 12-27 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)													
22b. SIGNATURE Richard H. Pollen MD					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. Pollen MD					22e. ADDRESS 10400 CONNECTICUT AVE KENSINGTON MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-29-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg Maryland					
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND					25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE [Signature]						

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DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 3 5 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert A. MUSTONE			2a. DATE OF DEATH MONTH DAY YEAR December 17 1979		2b. HOUR 2:28P M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 22 1921		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Army	12b. KIND OF BUSINESS OR INDUSTRY Retired	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia			13b. COUNTY Fairfax	13c. CITY OR TOWN Alexandria	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Mustone			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia D'Ambrosio		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 014 18 8787		17. INFORMANT ADDRESS Mrs. Jeannine J. Mustone See item 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) METASTATIC PANCREATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from Dec. 12 , 19 79 , to Dec. 17 , 19 79 , that (1) (we) last saw the deceased alive on Dec. 17 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE M.P. Vincent M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Dec. 18, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M.P. Vincent M.D.		22e. ADDRESS National Naval Medical Center, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Dec 19, 1979	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME DeMaine Funeral Home		ADDRESS Springfield, Va.		25a. DATE REC'D. BY REGISTRAR DEC 24 1979	25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCreedy</i>

BP

RECEIVED TO THE
OFFICE OF THE
DIRECTOR OF THE
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LAND OFFICE

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1913



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 3 5 1
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Benjamin P. Naddeo					2a. DATE OF DEATH MONTH DAY YEAR Dec. 28, 1979			2b. HOUR 920 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 2 1912		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adv. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Shoe Repairman		12b. KIND OF BUSINESS OR INDUSTRY		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Mont. 13c. CITY OR TOWN S.S.					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Manchester Place			
14. FATHER'S NAME FIRST MIDDLE LAST Vincenzo Naddeo					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Uriano					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None					16b. SOCIAL SECURITY NO 176 07 7614		17. INFORMANT ADDRESS Germantown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL FAILURE, CHF, HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) ANEMIA CHRONIC, ASHD, COPD PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 49 MIN					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 14, 1979 to DECEMBER 28, 1979 , that (I) (we) lost saw the deceased alive on DECEMBER 28, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Adrian Selfa MD DEGREE					22c. DATE SIGNED 12/28/79			22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADRIAN SELFA, MD		
22e. ADDRESS 7600 CARROLL AVE TAKOMA PARK, MD. 20012					22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/2/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.					25a. DATE JAN 4 1980 25b. REGISTRAR'S SIGNATURE [Signature]					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO. 79 31352									
1. DECEASED NAME (TYPE OR PRINT) Richard Charles Nale						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH 12 DAY 3 YEAR 1979					
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH (MONTH DAY YEAR) 10-21-25	6. AGE (IN YEARS BIRTHDAY YRS.) 54	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 12 3 79			2b. HOUR 11 MIN. 03		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9061 Manchester Rd. Silver Sp.			
14. FATHER'S NAME FIRST Jonathan MIDDLE W. LAST Nale						15. MOTHER'S MAIDEN NAME FIRST Ella MIDDLE Gertrude LAST Osborne					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT 210 18 8874		17. ADDRESS Rebecca Nale (Wife) Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4291 Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Rogers		TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER				DATE SIGNED Dec 3, 1979			
EXAMINER'S NAME (TYPE OR PRINT) John Rogers		ADDRESS 1919 Seminary Rd. S.S.Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/6/79		23c. NAME OF CEMETERY OR CREMATORY Acklin Cemetery				23d. LOCATION CITY OR TOWN Merristown COUNTY Pa. STATE Pa.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi		ADDRESS F.H.11800 N.H.Ave.S.S.Md.		25a. DATE RECD. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

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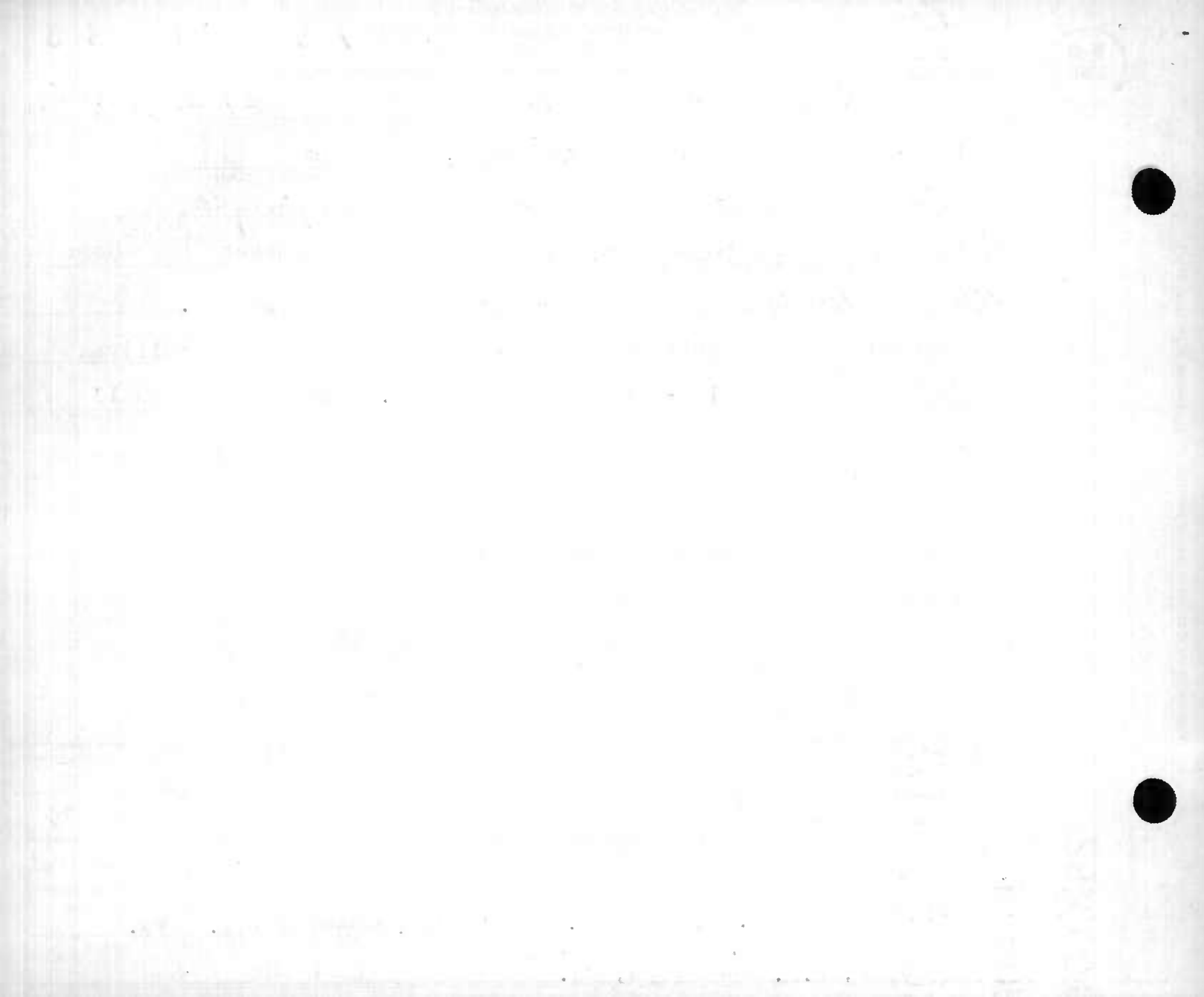
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 5 3

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Vera M Nauss		2a. DATE OF DEATH MONTH DAY YEAR 12 / 22 / 79 2b. HOUR 8:05 AM	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 02 / 19 / 93	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. AGE (IN YEARS (LAST BIRTHDAY)) 86 YRS	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. INSIDE CITY LIMITS? 13c. STREET ADDRESS Silver Spring, X+ NO 8484 16th St.	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Collins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Sullivan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 185-36-4431	
17. INFORMANT ADDRESS Patricia A. Nauss Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 496- DUE TO, OR AS A CONSEQUENCE OF (b) Chronic lung disease DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-20 19 79, to 12-22 19 79, that (I) (we) saw the deceased alive on 12-22 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.			
22b. SIGNATURE James Brodsky MD		22c. DATE SIGNED 12-22-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Brodsky MD		22e. ADDRESS 4701 Willard Ave. Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 26, 1979	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hanover Twp. Pa.	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.		25a. DATE REC'D. BY REGISTRAR DEC 27 1979	
		25b. REGISTRAR'S SIGNATURE Anthony McCready	

BP

DHMH-16 20M
(VRA 15, 4) 7/78



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 31354	
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Peyton G. Nevitt						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Dec. 1, 1979		2b. HOUR 2:35a			
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Nov. 11 1894	6. AGE (IN YEARS) (LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 19		2d. HOUR M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Army		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Clarksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 23730 Frederick Road					
14. FATHER'S NAME FIRST MIDDLE LAST Robert I. Nevitt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne A. Scrivener									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WWI & WWII		16b. SOCIAL SECURITY NO. 215-46-1288		17. INFORMANT NAME ADDRESS Catherine N. Sherwood Wheaton, Md. 212404 Feldon St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction, Ant. Wall 2500 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) Thromb. of L. and R. A. - Recent										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few DAYS Years.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE J. Minarick				TITLE (SPECIFY) Pathologist				DATE SIGNED 12/1/79					
EXAMINER'S NAME (TYPE OR PRINT) J. Minarick MD				ADDRESS Mont. Gen. Hosp.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12-2-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va.							
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey					

10

1000 11 1800 32

Washington, D.C. U.S.A.

Office of the Secretary of Defense

Mr. Robert A. Johnson

Mr. Johnson

Mr. Johnson

1000 11 1800 32

1000 11 1800 32

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 1 3 5 5 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Doris A. Newquist								12 13 79		2 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		white		11 5 1979		60		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Minnesota		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital						Housewife		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Montgomery		Rockville				YES <input type="checkbox"/> NO <input type="checkbox"/>		1800 McAuliffe Drive	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Knutte Andral		Inga Gulbrandson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
no		469-18-5137		Russell P. Newquist same as 13e							
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>										minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Electrolyte imbalance</u>										Days	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple sclerosis</u>										15 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>340-</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 65</u> , to <u>12/12</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
<u>Richard F. Delaney</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
RICHARD F. DELANEY MD		4323 HARVARD ST S.E. MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12/15/79		Parklawn Memorial Park		Rockville, Maryland					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR SIGNATURE					
Tyson Wheeler Funeral Home, Inc.		DEC 19 1979				<u>[Signature]</u>					
1331 Rockville Pike Rockville, Md. 20852											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
George L. Nicol				12-4-79		8:40 P M			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
MALE		WHITE		MONTH DAY YEAR Nov. 13, 1903		76 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Greece		USA				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hosp.		Geologist		Study Of Earth			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b INSIDE CITY LIMITS?		13c STREET ADDRESS					
Md.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4601 N. Park Ave.					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Leonidas Nicolopoulos		FIRST MIDDLE LAST Dina Karamesiwes							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
No		569-30-1813		Conchita Nicol- Same as Item # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140		DUE TO, OR AS A CONSEQUENCE OF (b) Congestive failure		2-3 years					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerotic heart disease		years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from September 29, 1979, to 12/4, 1979, that (I) (we) lost saw the deceased alive on 12/4/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b SIGNATURE		DEGREE		22c DATE SIGNED			
JACK P. SEGAL		M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		12/4/79		Clay Choe MD 20015	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Cremation		12/6/79		Cedar Hill Crematory		Suitland, Md.			
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Joseph Gawler's Sons, Inc.		DEC 13 1979		History McBrady					
5130 Wisc. Ave. N.W. Wash., D.C.									

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MYRTIE Murphy Bell Norris			2a. DATE OF DEATH MONTH DAY YEAR December 1, 1979			2b. HOUR 7:46AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC 17, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PEPCO		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14005 BROOMALL LANE	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES W. HURST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE BELL PAXSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-0155		17. INFORMANT ADDRESS MYRTIE CLAIRE BROWN SAME AS 13 DAUGHTER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days 11 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from 20 Nov 1979 to 1 Dec 1979 , that (1) (we) lost saw the deceased alive above (1) (we) (did) (not) view the body after death 30 Nov 1979 and that in my (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE Lewis Kellart, MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellart, MD			22e. ADDRESS 1811 Prince Phillip Dr. Olney, MD. 20832						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/4/79		23c. NAME OF CEMETERY OR CREMATORY CHESTNUT GROVE		23d. LOCATION CITY OR TOWN COUNTY STATE HERNDON VIRGINIA		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS			ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			25a. DATE REC'D. BY REGISTRAR DEC 3 1979		25b. REGISTRAR'S SIGNATURE Robert J. Brady	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

WHITE

WHITE 1902

U.S.A.

1002 KODWALL LANE

CHARLES M. FIRST WHITE TALL TAYSON

197-02-0125 WHITE CLARE BROWN SUE AS 13 TAYSON



RECEIVED
JUN 10 1964
FBI
197-02-0125
WHITE CLARE BROWN
SUE AS 13 TAYSON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IN EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31358			
1- FOR STATE REGISTRAR										7 DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR		7b HOUR	
1 DECEASED NAME FIRST MIDDLE LAST Thanh Thi NGUYEN										12/31 19 79		M	
3 SEX Female		4 RACE Oriental		5 DATE OF BIRTH MONTH DAY YEAR 1886 94 YRS.		6 AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD 12/31 19 79		24 HOUR 10:17 A.M.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIET NAM				7b CITIZEN OF WHAT COUNTRY? VIET NAM				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Silver Spring				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 826 Wayne Avenue				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland				13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 826 Wayne Avenue			
14 FATHER'S NAME FIRST MIDDLE LAST THAI NGUYEN						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THALNG NGUYEN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 587-40-9606				17 INFORMANT ADDRESS THAO NGUYEN SAME AS 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None													
19a DATE OF OPERATION None				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED 12/31/79					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b DATE 1/3/80		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a DATE REC'D. BY REGISTRAR JAN 2 1980		25b REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>			

16

DATE: MAY 1961

TO: THE DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: JAMES EARL RAY
RE: NEW YORK TELETYPE TO BUREAU, MAY 12, 1961

RE: NEW YORK TELETYPE TO BUREAU, MAY 12, 1961

RE: NEW YORK TELETYPE TO BUREAU, MAY 12, 1961

RE: NEW YORK TELETYPE TO BUREAU, MAY 12, 1961

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31359

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST Ned		MIDDLE A		LAST Ochiltree, Sr.		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 26 19 79		2b. HOUR 6:30 PM	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1894		6. AGE (IN YEARS) LAST BIRTHDAY 85 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Dec. 26 1979		2d. HOUR 6:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bd. Chairman		12b. KIND OF BUSINESS OR INDUSTRY Construction		Prod.					
13a. STATE Illinois		13b. COUNTY Cook		13c. CITY OR TOWN River Forest		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7601 Division St.					
14. FATHER'S NAME FIRST MIDDLE LAST Herman B. Ochiltree		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leda Vorhees		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW I		17. INFORMANT David Ochiltree		ADDRESS 5112 Scarsdale Rd. Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Acute Cystitis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John G. Ball		TITLE (SPECIFY) M.D. J. Poty		MEDICAL EXAMINER 7936 Old Georgetown Rd. Bethesda, Maryland		DATE SIGNED Dec. 26, 1979							
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball		ADDRESS Bethesda, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 29, 1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Emblem Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Elmhurst, Illinois							
24. FUNERAL DIRECTOR NAME Homes, P.A.		ADDRESS Bethesda, Md.		25a. DATE REC'D. BY REGISTRAR DEC 31 1979		25b. REGISTRAR'S SIGNATURE Mortimer M. Brady							

REPORT OF THE BOARD OF DIRECTORS
OF THE NATIONAL ASSOCIATION OF REALTORS
FOR THE YEAR 1912

1912	1911	1910	1909	1908	1907	1906	1905	1904	1903	1902	1901	1900	1899	1898	1897	1896	1895	1894	1893	1892	1891	1890	1889	1888	1887	1886	1885	1884	1883	1882	1881	1880	1879	1878	1877	1876	1875	1874	1873	1872	1871	1870	1869	1868	1867	1866	1865	1864	1863	1862	1861	1860	1859	1858	1857	1856	1855	1854	1853	1852	1851	1850	1849	1848	1847	1846	1845	1844	1843	1842	1841	1840	1839	1838	1837	1836	1835	1834	1833	1832	1831	1830	1829	1828	1827	1826	1825	1824	1823	1822	1821	1820	1819	1818	1817	1816	1815	1814	1813	1812	1811	1810	1809	1808	1807	1806	1805	1804	1803	1802	1801	1800	1799	1798	1797	1796	1795	1794	1793	1792	1791	1790	1789	1788	1787	1786	1785	1784	1783	1782	1781	1780	1779	1778	1777	1776	1775	1774	1773	1772	1771	1770	1769	1768	1767	1766	1765	1764	1763	1762	1761	1760	1759	1758	1757	1756	1755	1754	1753	1752	1751	1750	1749	1748	1747	1746	1745	1744	1743	1742	1741	1740	1739	1738	1737	1736	1735	1734	1733	1732	1731	1730	1729	1728	1727	1726	1725	1724	1723	1722	1721	1720	1719	1718	1717	1716	1715	1714	1713	1712	1711	1710	1709	1708	1707	1706	1705	1704	1703	1702	1701	1700	1699	1698	1697	1696	1695	1694	1693	1692	1691	1690	1689	1688	1687	1686	1685	1684	1683	1682	1681	1680	1679	1678	1677	1676	1675	1674	1673	1672	1671	1670	1669	1668	1667	1666	1665	1664	1663	1662	1661	1660	1659	1658	1657	1656	1655	1654	1653	1652	1651	1650	1649	1648	1647	1646	1645	1644	1643	1642	1641	1640	1639	1638	1637	1636	1635	1634	1633	1632	1631	1630	1629	1628	1627	1626	1625	1624	1623	1622	1621	1620	1619	1618	1617	1616	1615	1614	1613	1612	1611	1610	1609	1608	1607	1606	1605	1604	1603	1602	1601	1600	1599	1598	1597	1596	1595	1594	1593	1592	1591	1590	1589	1588	1587	1586	1585	1584	1583	1582	1581	1580	1579	1578	1577	1576	1575	1574	1573	1572	1571	1570	1569	1568	1567	1566	1565	1564	1563	1562	1561	1560	1559	1558	1557	1556	1555	1554	1553	1552	1551	1550	1549	1548	1547	1546	1545	1544	1543	1542	1541	1540	1539	1538	1537	1536	1535	1534	1533	1532	1531	1530	1529	1528	1527	1526	1525	1524	1523	1522	1521	1520	1519	1518	1517	1516	1515	1514	1513	1512	1511	1510	1509	1508	1507	1506	1505	1504	1503	1502	1501	1500	1499	1498	1497	1496	1495	1494	1493	1492	1491	1490	1489	1488	1487	1486	1485	1484	1483	1482	1481	1480	1479	1478	1477	1476	1475	1474	1473	1472	1471	1470	1469	1468	1467	1466	1465	1464	1463	1462	1461	1460	1459	1458	1457	1456	1455	1454	1453	1452	1451	1450	1449	1448	1447	1446	1445	1444	1443	1442	1441	1440	1439	1438	1437	1436	1435	1434	1433	1432	1431	1430	1429	1428	1427	1426	1425	1424	1423	1422	1421	1420	1419	1418	1417	1416	1415	1414	1413	1412	1411	1410	1409	1408	1407	1406	1405	1404	1403	1402	1401	1400	1399	1398	1397	1396	1395	1394	1393	1392	1391	1390	1389	1388	1387	1386	1385	1384	1383	1382	1381	1380	1379	1378	1377	1376	1375	1374	1373	1372	1371	1370	1369	1368	1367	1366	1365	1364	1363	1362	1361	1360	1359	1358	1357	1356	1355	1354	1353	1352	1351	1350	1349	1348	1347	1346	1345	1344	1343	1342	1341	1340	1339	1338	1337	1336	1335	1334	1333	1332	1331	1330	1329	1328	1327	1326	1325	1324	1323	1322	1321	1320	1319	1318	1317	1316	1315	1314	1313	1312	1311	1310	1309	1308	1307	1306	1305	1304	1303	1302	1301	1300	1299	1298	1297	1296	1295	1294	1293	1292	1291	1290	1289	1288	1287	1286	1285	1284	1283	1282	1281	1280	1279	1278	1277	1276	1275	1274	1273	1272	1271	1270	1269	1268	1267	1266	1265	1264	1263	1262	1261	1260	1259	1258	1257	1256	1255	1254	1253	1252	1251	1250	1249	1248	1247	1246	1245	1244	1243	1242	1241	1240	1239	1238	1237	1236	1235	1234	1233	1232	1231	1230	1229	1228	1227	1226	1225	1224	1223	1222	1221	1220	1219	1218	1217	1216	1215	1214	1213	1212	1211	1210	1209	1208	1207	1206	1205	1204	1203	1202	1201	1200	1199	1198	1197	1196	1195	1194	1193	1192	1191	1190	1189	1188	1187	1186	1185	1184	1183	1182	1181	1180	1179	1178	1177	1176	1175	1174	1173	1172	1171	1170	1169	1168	1167	1166	1165	1164	1163	1162	1161	1160	1159	1158	1157	1156	1155	1154	1153	1152	1151	1150	1149	1148	1147	1146	1145	1144	1143	1142	1141	1140	1139	1138	1137	1136	1135	1134	1133	1132	1131	1130	1129	1128	1127	1126	1125	1124	1123	1122	1121	1120	1119	1118	1117	1116	1115	1114	1113	1112	1111	1110	1109	1108	1107	1106	1105	1104	1103	1102	1101	1100	1099	1098	1097	1096	1095	1094	1093	1092	1091	1090	1089	1088	1087	1086	1085	1084	1083	1082	1081	1080	1079	1078	1077	1076	1075	1074	1073	1072	1071	1070	1069	1068	1067	1066	1065	1064	1063	1062	1061	1060	1059	1058	1057	1056	1055	1054	1053	1052	1051	1050	1049	1048	1047	1046	1045	1044	1043	1042	1041	1040	1039	1038	1037	1036	1035	1034	1033	1032	1031	1030	1029	1028	1027	1026	1025	1024	1023	1022	1021	1020	1019	1018	1017	1016	1015	1014	1013	1012	1011	1010	1009	1008	1007	1006	1005	1004	1003	1002	1001	1000	999	998	997	996	995	994	993	992	991	990	989	988	987	986	985	984	983	982	981	980	979	978	977	976	975	974	973	972	971	970	969	968	967	966	965	964	963	962	961	960	959	958	957	956	955	954	953	952	951	950	949	948	947	946	945	944	943	942	941	940	939	938	937	936	935	934	933	932	931	930	929	928	927	926	925	924	923	922	921	920	919	918	917	916	915	914	913	912	911	910	909	908	907	906	905	904	903	902	901	900	899	898	897	896	895	894	893	892	891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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7 9 3 1 3 6 0				
1. FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
Ruth B. Oldham					Dec. 11, 1979					10 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		Caucasian		9/7/1898		81			MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Pennsylvania		U.S.A.				Montgomery MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Rockville		13902 Dowlais Dr.				Homemaker			Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13902 Dowlais Dr.		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
UNKNOWN					UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No					577-22-7717		Charles H. Oldham, Jr. same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <u>Alcohol and Congestive Heart Failure</u>										9 mos.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>215</u> , 19 <u>79</u> , to <u>12 11</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12 11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE						DEGREE				22c. DATE SIGNED				
<u>James M. D'Angelo, M.D.</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12/11/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS								
James M. D'Angelo						5401 Western Ave. N.W. Wash., D.C.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial				12/14/79		Cedar Hill Cemetery				Suitland, Maryland				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
Robert A. Pumphrey Funeral Homes, P.A. 300 West Montgomery Ave., Rockville, MD						DEC 17 1979				<u>[Signature]</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 3 6 1 REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) MYRNA L OLIVER			2a DATE OF DEATH MONTH DAY YEAR 12-19-79			2b HOUR 4 PM				
3 SEX F		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 3 33		6 AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist		12b KIND OF BUSINESS OR INDUSTRY Medical			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 15412 Quail Run Drive	
14 FATHER'S NAME FIRST MIDDLE LAST Milton Kreger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Gordon							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 151-26-1468		17. INFORMANT ADDRESS Maryland Jodi Oliver; 15412 Quail Run Dr., Gaithersburg					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure DUE TO, OR AS A CONSEQUENCE OF, (b) Hepatic Necrosis DUE TO, OR AS A CONSEQUENCE OF, (c) Suspected Viral Hepatitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days weeks										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Gangrene of Cecum -										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/30 , 19 79 , to 12/19 , 19 79 , that (I) (we) lost saw the deceased alive on 12/19 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Stephen J. Newman			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN J. NEWMAN, M.D.			22e. ADDRESS 5411 W. Cedar Lane, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-79		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Maryland				
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels;		ADDRESS 1170 Rockville Pike		25a. DATE RECD. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE [Signature]				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

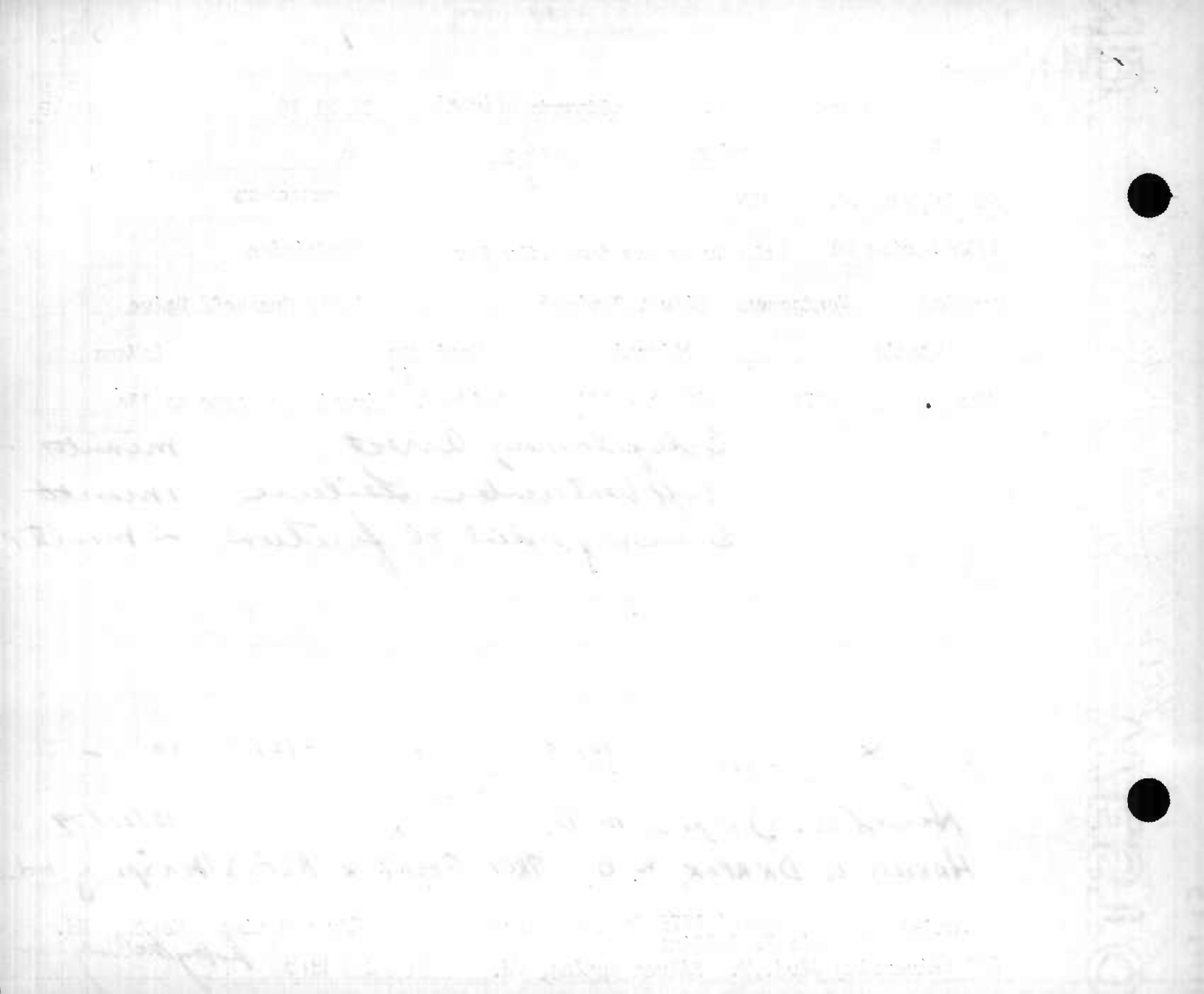
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 3 6 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Andrew J. Oliveria Oliveri			2a. DATE OF DEATH 12 21 79		2b. HOUR 3:14 PM		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 5 DAY 08 YEAR 18			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital Silver Spr Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring			
14. FATHER'S NAME FIRST Antonio MIDDLE Oliveri LAST LaMana		15. MOTHER'S MAIDEN NAME FIRST Marietta MIDDLE LaMana LAST LaMana		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b. SOCIAL SECURITY NO. 578-12-5204		17. INFORMANT wife		17. ADDRESS same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Left Ventricular Failure (c) Severe myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 1 month 2 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/1/5 , 19 79 , to 12/21 , 19 79 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 12/13 , 19 79 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22a. SIGNATURE Harold W. Draper M.D.		22b. ADDRESS 9801 GEORGIA AVE, Silver Spring, Md.		22c. DATE SIGNED 12/21/79			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 24, 1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven			
23d. LOCATION CITY OR TOWN Silver Spring		23e. COUNTY Mont		23f. STATE Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			



18

Items 18a & b. G540 2/22/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1- STATE REGISTRAR

CERTIFICATE OF DEATH

REG. NO. 31363

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sigurd N. OLSEN Olsen		2a. DATE OF DEATH MONTH DAY YEAR 12/12/79		2b. HOUR 4:30 PM	
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 5/14/96		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley N. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Main. Supt.		12b. KIND OF BUSINESS OR INDUSTRY Subway
13a. STATE Maryland		13b. COUNTY Mont.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew - Olsen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret - Simenson		16. ADDRESS 4100 Muncaster Rd. Derwood, Md. 20855	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 082-32-6644		17. INFORMANT Russell K. Olsen	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cachexia 2° to cancer of pharynx</u> <u>Severe Cachexia due to Ca of pharynx</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma to lung & pleura</u> <u>Carcinoma of the larynx & trachea</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4-11-79</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 yrs.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/28</u> 19 <u>79</u> , to <u>12/12</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/5/79</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Natural</u>					
22b. SIGNATURE <u>Elba J. Martinez, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/12/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELBA J. MARTINEZ, M.D.		22e. ADDRESS 8808 HIDDEN HILL LANE - POTOMAC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 13, 1979		23c. NAME OF CEMETERY OR CREMATORY Wee Funeral Home	
23d. LOCATION Washington, D.C.		23e. STATE			
24. FUNERAL DIRECTOR Francis H. Barber		Laytonville, Md. 20760		25a. DATE REC'D. BY REGISTRAR DEC 17 1979	
25b. REGISTRAR'S SIGNATURE <u>Elba J. Martinez</u>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

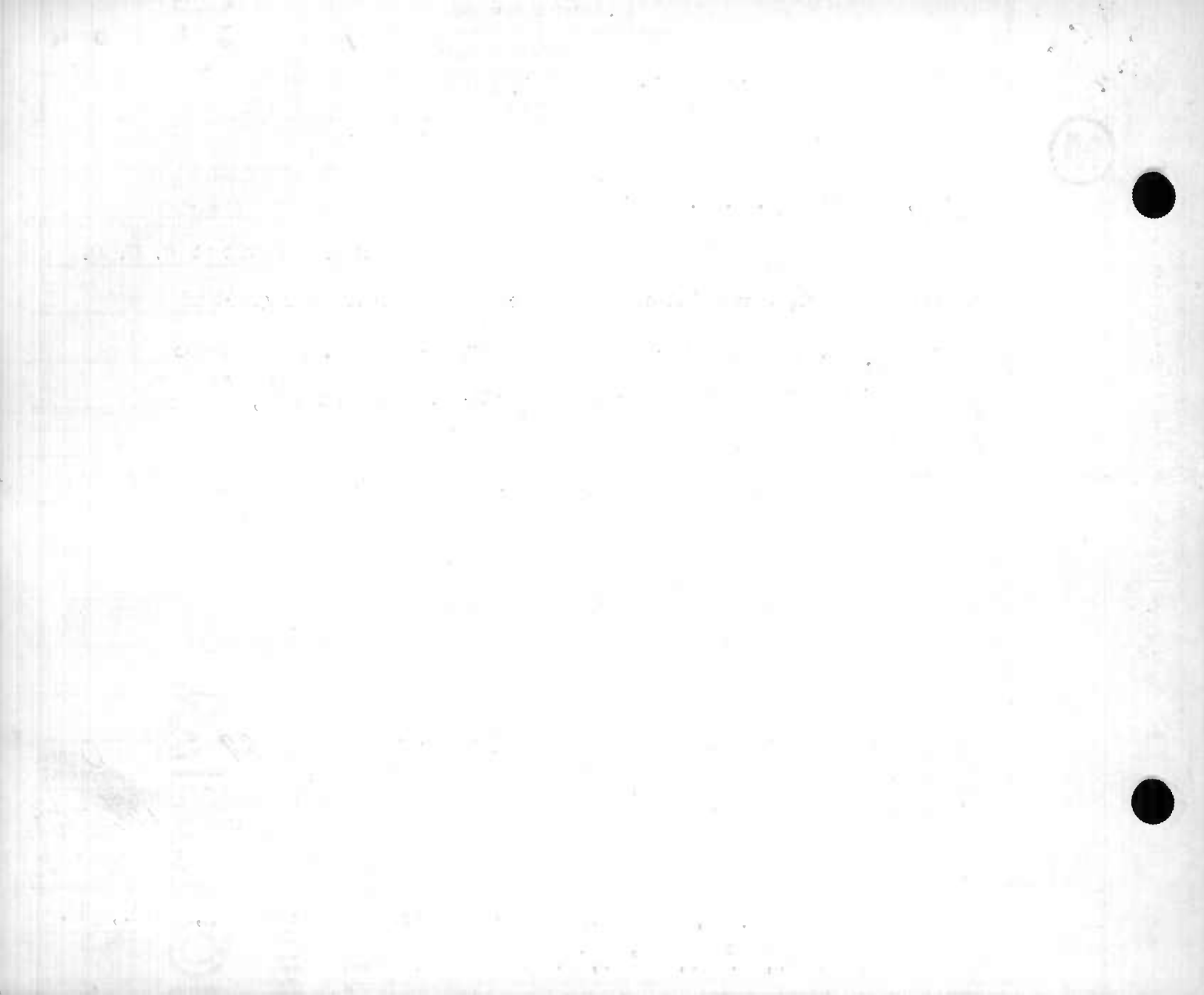
Body released by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 7 9 3 1 3 6 4						
1. DECEASED NAME (TYPE OR PRINT) Rudolph F. Olson			2a. DATE OF DEATH MONTH DAY YEAR 12 27 79			2b. HOUR 1 45 PM			
3 SEX M		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 09 27 10		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chicago, Illinois		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired accountant		12b. KIND OF BUSINESS OR INDUSTRY H. U. D.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. CITY OR TOWN Montgomery		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9906 Belhaven Road		
14. FATHER'S NAME FIRST MIDDLE LAST Oscar A. Olson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice B. Beranek						
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT 9906 Belhaven Road Loretta R. Olson Bethesda, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HRS 24 HRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> 19 <u>79</u> , to <u>12/27</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/27</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Roger Stevenson</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER STEVENSON, M.D.			22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 31, 1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Mont., Md.		
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., N. W., Wash., D. C.					25a. DATE REC'D. BY REGISTRAR AN 4 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31365				
1. DECEASED NAME (TYPE OR PRINT) STEFAN					FIRST XXXXXX					MIDDLE E.					LAST Pasche					2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12 12 19 79		2b. HOUR M		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR AUG 13, 1948		6. AGE (IN YEARS) LAST BIRTHDAY) 31 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 12 12 19 79		2d. HOUR 5:15 A.M.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County					MD.				
10. CITY OR TOWN OF DEATH Silver Springs					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11311 Old Columbia Pike					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN					12b. KIND OF BUSINESS OR INDUSTRY SEARS									
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY					13c. CITY OR TOWN SILVER SPRING					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11311 OLD COLUMBIA PIKE							
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT E. PASCHE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEANETTE ZWERLE					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 559-74-9335					17. INFORMANT FATHER ADDRESS 10301 PARKWOOD DR KENSINGTON, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) Multiple drug intoxication															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.																								
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																								
(c) _____ DUE TO, OR AS A CONSEQUENCE OF																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																								
ACTUAL SIGNATURE H. Guard					TITLE (SPECIFY) Assistant										DATE SIGNED 12/12/79									
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.					ADDRESS 111 Penn Street, Balto., MD 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION					23b. DATE 12/13/79					23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY					23d. LOCATION CITY OR TOWN COUNTY ALEXANDRIA VIRGINIA									
24. FUNERAL DIRECTOR FRANCIS J. COLLINS										25a. DATE REC'D. BY REGISTRAR DEC 17 1979					25b. RECEIVED BY John J. S. S.									
NAME ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																								

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 6 6

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Ruth E Pepper		2a. DATE OF DEATH MONTH 12 DAY 6 YEAR 79 2b. HOUR 11:30 P.M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH Oct. DAY 9 YEAR 1916	
6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH Bethesda	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST Harry MIDDLE LAST Knight		15. MOTHER'S MAIDEN NAME FIRST Lillian MIDDLE LAST Day	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 577-01-3349	
17. INFORMANT daughter ADDRESS 7713 Woodstock St. Manassas, Va. 22110		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Primary Carcinoma Breast DUE TO, OR AS A CONSEQUENCE OF (c) 	
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
19a. DATE OF OPERATION 1971		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Breast	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1976 to Dec 6 19 79 , that (1) yes saw the deceased alive on Dec 6 19 79 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (1) yes (2) no (3) no (4) no		22b. SIGNATURE James W. Fagan M.D. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 12/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Fagan		22e. ADDRESS 5413 Cedar Ln. - Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 10, 1979	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood COUNTY Pr. Geo. STATE Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR DEC 12 1979 25b. REGISTRAR'S SIGNATURE Barbara A. Brady	

MEDICAL CERTIFICATION

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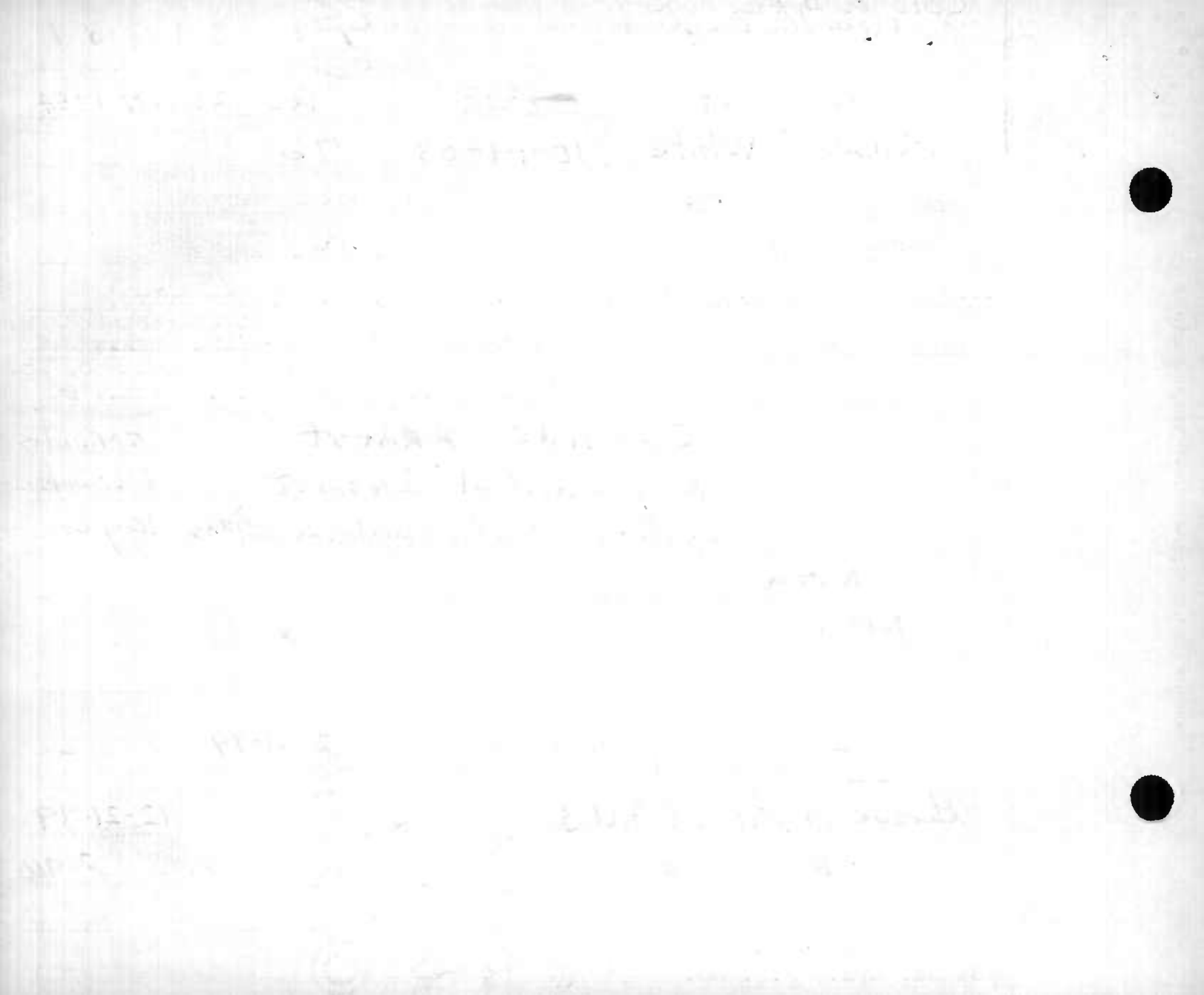
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR RELEASED BODY				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 3 1 3 6 7			
1. STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Relta G Peterson				2a. DATE OF DEATH MONTH DAY YEAR Dec 21, 1979				2b. HOUR 1:05A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-19-03		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown		7b. CITIZEN OF WHAT COUNTRY? USA		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4003 Shaler Drive,				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired teacher		12b. KIND OF BUSINESS OR INDUSTRY Schools			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4003 Shaler Drive,			
14. FATHER'S NAME FIRST MIDDLE LAST Minnie Eddie Gregory				15. MOTHER'S MAIDEN NAME Minnie Miller				16. SOCIAL SECURITY NO. 445-28-3050			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -----				16b. SOCIAL SECURITY NO. 445-28-3050				17. INFORMANT (son) ADDRESS 1746 Crestwood Dr. William D. Peterson N.W. Wash., DC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST 410- DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Minutes 6 weeks 10 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (the hospital) attended the deceased from 11-11-79 19 to 12-21-79 19, that (I) (we) lost saw the deceased alive on 12-20-79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22a. SIGNATURE George B. Patrick JMD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-21-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George B. Patrick JMD				22e. ADDRESS 9221 Colesville Road, S.S. Md. 20916							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 26, 1979		23c. NAME OF CEMETERY OR CREMATORY Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Oklahoma City Oklahoma		23e. DATE REC'D. BY REGISTRAR 12-25-79	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25. REGISTRAR'S SIGNATURE R. B. Brady							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician or funeral director must be notified at once.

RELEASED BY BR. JOHN BALL, MEDICAL EXAMINER

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Bettie G. Peyraud				12/2/79		1:45p _M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		10/2/1891		88 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Iowa		U.S.A.				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital				Housewife		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4998 Battery Lane		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Henry Gray					Alice (Unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS		
No		319-26-6796		Angela Hinton/Daughter			4406 Saul Rd. Kensington, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA, BREAST</u>								1 1/2 HOURS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>HIATUS HERNIA, DIAPHRAGMATIC</u>								15 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								26 YEARS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1961</u> , 19 <u>61</u> , to <u>Dec 2</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Nov. 15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Philip R. James</u> M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12.2.79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip R. James				22e. ADDRESS <u>5401 Western Ave., Washington, D.C. 20015</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		23b. DATE <u>Dec 3, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Medical School</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR NAME <u>Capitol Funeral Service</u> ADDRESS <u>Fairfax, Va.</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 6 1979</u>		25b. REGISTRAR'S SIGNATURE <u>John Ball</u>			

REMIWAX JACIDN JIAGL • 88 • 01M 8811 MEDICAL EXAMINER

12/1/78	1:43P	Female	White	10/2/1951	12/1/78	1:43P
Montgomery County	Montgomery County	Montgomery County	Montgomery County	Montgomery County	Montgomery County	Montgomery County
Suburban Hospital	Suburban Hospital	Suburban Hospital	Suburban Hospital	Suburban Hospital	Suburban Hospital	Suburban Hospital
4998 BATTERY LANE	4998 BATTERY LANE	4998 BATTERY LANE	4998 BATTERY LANE	4998 BATTERY LANE	4998 BATTERY LANE	4998 BATTERY LANE
White	White	White	White	White	White	White

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

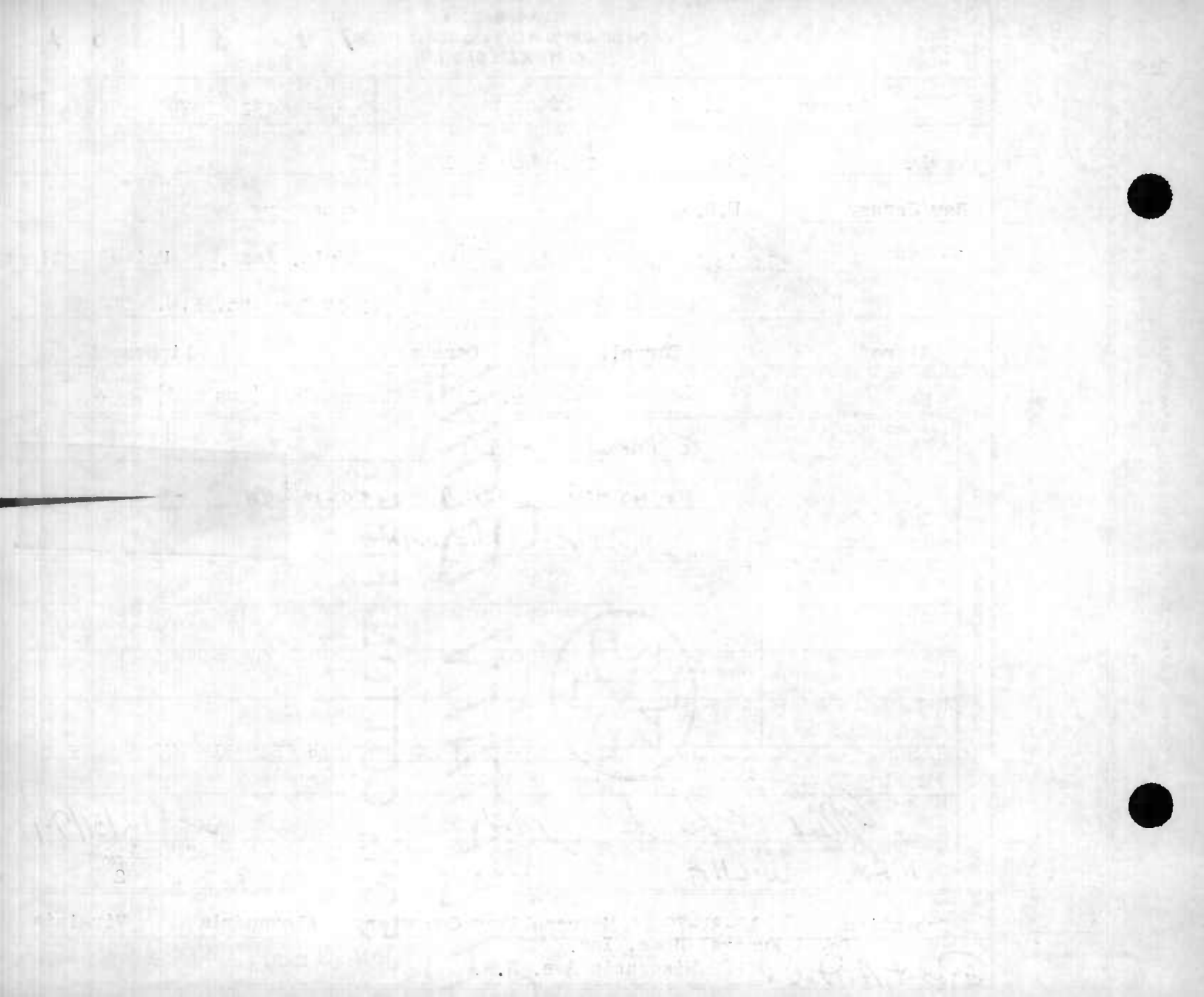
1. DECEASED NAME (TYPE OR PRINT) Achsah D. Pitcher			2a. DATE OF DEATH MONTH DAY YEAR December 31, 1979			2b. HOUR 5:00 AM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 3, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md. NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Admin. Asst.		12b. KIND OF BUSINESS OR INDUSTRY United Nations	
13a. STATE DC		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1617 33rd St. N.W. 20007			
14 FATHER'S NAME FIRST MIDDLE LAST Alfred Darnell			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ocneva Lippencott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 160-24-2075		17 INFORMANT ADDRESS same as Mr. Allan Pitcher, NOK (husband) above				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> 2030 DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC BREAST CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MULTIPLE MYELOMA</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 16, 1979, to December 31, 1979, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on December 31, 1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE MAX WICHA			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX WICHA			22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12-31-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR DeVol Funeral Home, Inc. Robert A. DeVol 2222 Wisconsin Ave. N.W.					25a. DATE REC'D. BY REGISTRAR JAN 9 1980		25b. REGISTRAR'S SIGNATURE		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 must be completed.





DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 49 31370									
1- STATE REGISTRAR												2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR					
1. DECEASED NAME FIRST MIDDLE LAST Carlin C Poland												2c. DATE ESTI- MATED		MONTH DAY YEAR		2d. HOUR					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR					
male		white		1 12 08		71 YRS.						12 17 19 79		9:52pm		9:52pm					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD					
Virginia				USA								Montgomery									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring				Holy Cross Hospital				retired				US Govt									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
												Maryland		Montgomery		Wheaton		YES		1902 Franwall Ave	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Joseph Poland						Clemie Crouch															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
Yes				WWII				577-26-3740A				wife, Ulda Poland 1902 Franwall Ave. Silver Spring, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Xrd.</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<u>None</u>																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>John S. Rogers</u>				TITLE (SPECIFY) M.D. <u>Dep.</u>				MEDICAL EXAMINER				DATE SIGNED <u>Dec 18 1979</u>									
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers				ADDRESS 1919 Seminar Rd. Silver Spring, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 21, 79				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia									
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				25a. DATE REC'D. BY REGISTRAR DEC 20 1979				25b. REGISTRAR'S SIGNATURE <u>Robert H. Hines</u>													
11800 New Hampshire Ave. Silver Spring, Md.																					



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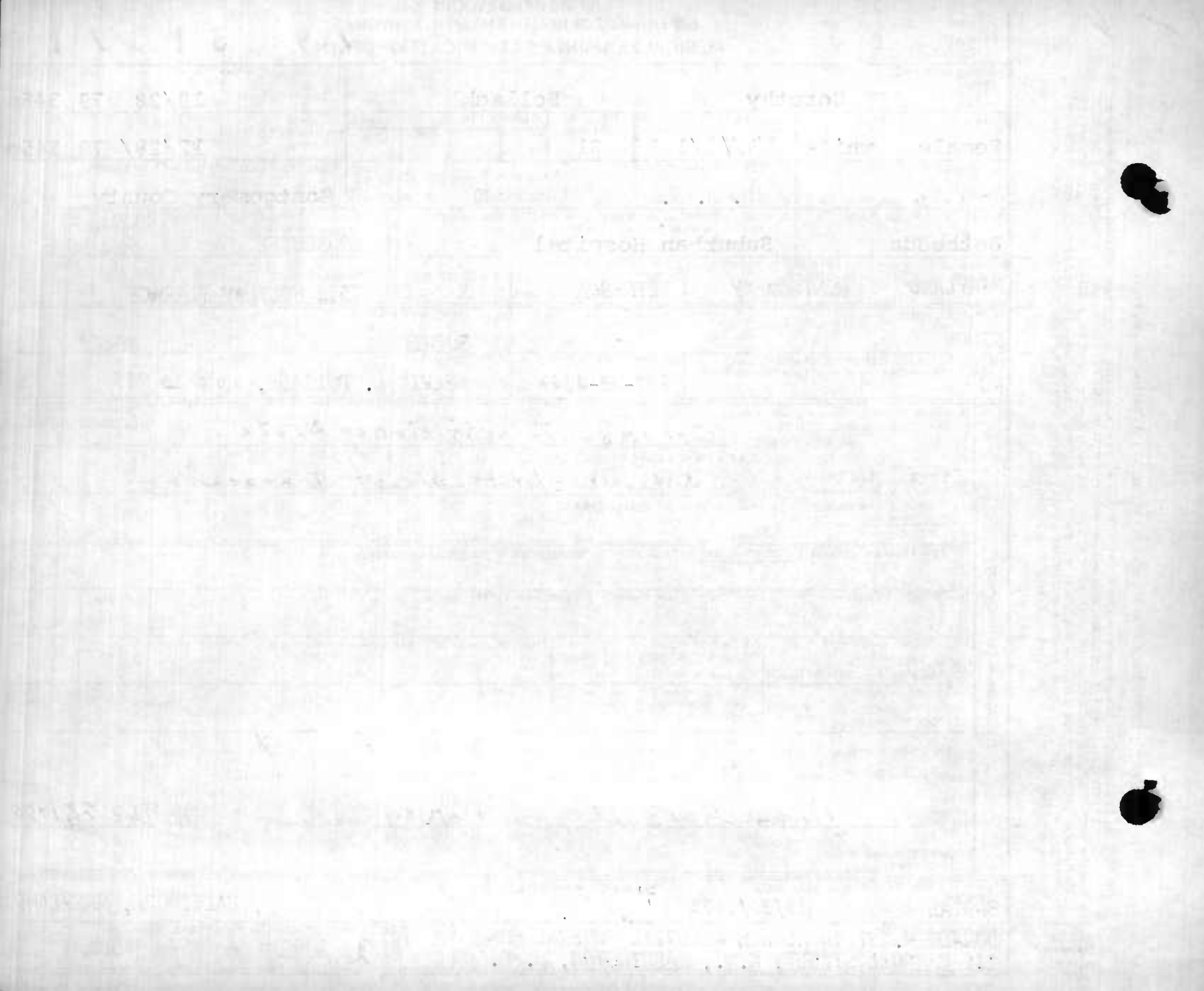
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31371	
1. DECEASED NAME (TYPE OR PRINT) Dorothy Pollack										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12/28 1979 345p										2b. HOUR	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 3/25/1899		6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 12/28/1979		2d. HOUR							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD									
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY OWN HOME									
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7512 HOLIDAY TERRACE											
14. FATHER'S NAME FIRST MIDDLE LAST SIMON BERMAN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE SOBER															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-03-4249		17. INFORMANT ADDRESS MELVIN M. POLLACK, same as #13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute. 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Heart Disease. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE John E. Ball				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED Dec, 28/1979									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/30/1979		23c. NAME OF CEMETERY OR CREMATORY B' NAI ISRAEL CONGREGATION CEMETERY				23d. LOCATION CITY OR TOWN COUNTY BALTIMORE, BALTIMORE, MARYLAND											
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR JAN 2 1980				25b. REGISTRAR'S SIGNATURE John E. Ball													
23e. ADDRESS 232 CARROLL STREET, N.W., WASHINGTON, D. C.																					





FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herman Press			2a. DATE OF DEATH MONTH DAY YEAR December 12, 1979		2b. HOUR 3:40 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 12, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retailer (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Food
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Brookville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3009 Quail Hollow Terrace	
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Press			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Agen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 087-18-8894		17. INFORMANT ADDRESS Charlotte Magliaro; 3009 Quail Hollow Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) pancreatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) diabetes APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs. 10 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept 1979 to Dec 12, 1979 , that (I) (we) lost saw the deceased alive on 12/12/79 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward P. Paulman		DEGREE M.D.		22c. DATE SIGNED 12/12/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward P. Paulman		22e. ADDRESS 18111 Prince Philip Dr. Olney Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-14-79		23c. NAME OF CEMETERY OR CREMATORY Mt. Ararat Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Farmingdale, L.I. New York		24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg Chapels; 1170 Rockville Pike Rockville, Md.			
25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1945

TO HOSPITAL: ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

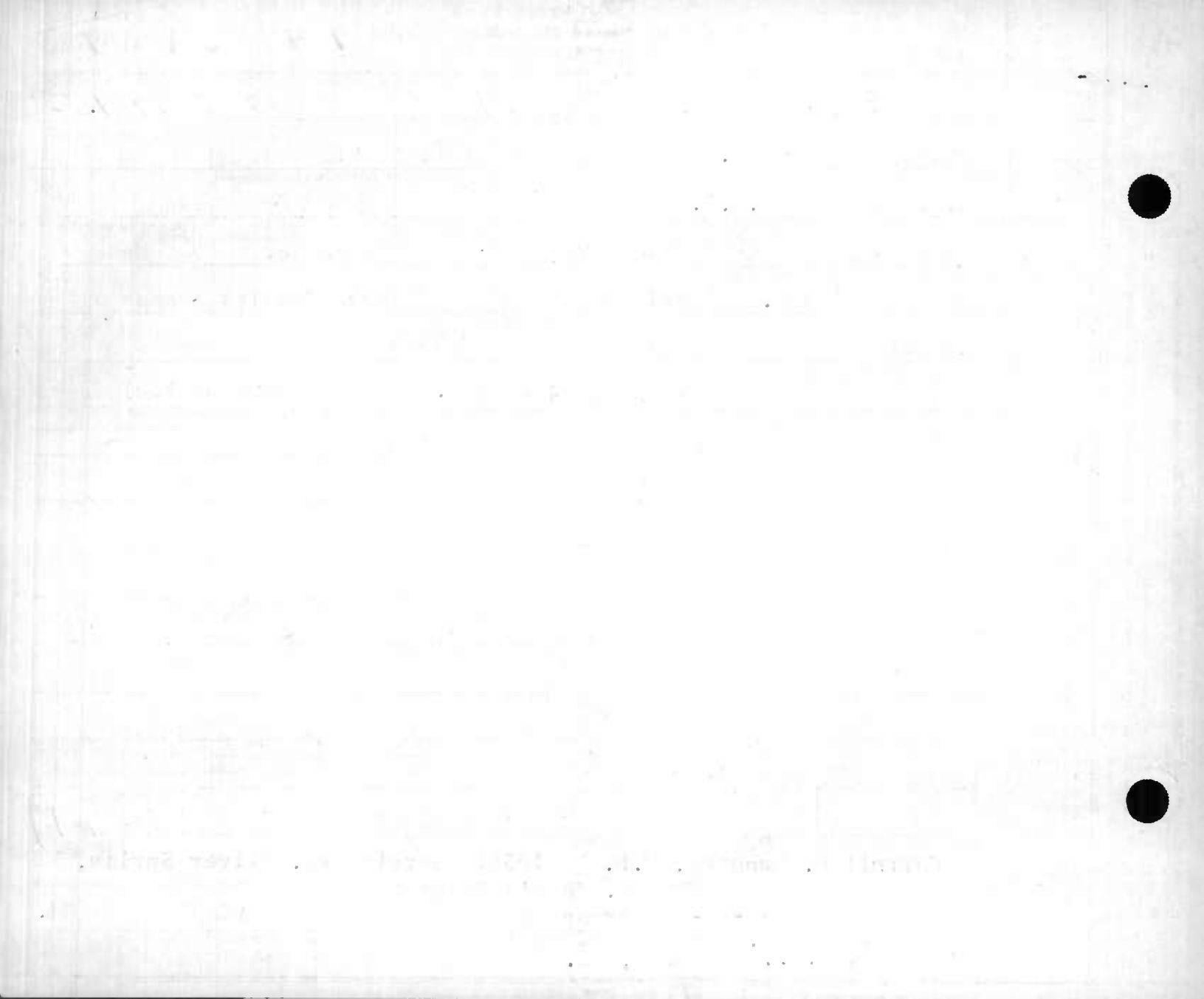
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 7 3
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Hilda H. Prevail		2a DATE OF DEATH MONTH DAY YEAR 12 7 79		2b HOUR 12 ⁴⁰ A.M.	
3 SEX Female	4 RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR June 5 1912		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE MD		13c CITY OR TOWN Montg. Kensington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Michael Wade		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 214 52 3684		17 INFORMANT ADDRESS Frank H. Prevail (Same as 13e)	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sybaricoid Hemorrhage 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 12-11-79, 1975 to Dec 6, 1979, that (I) (we) lost saw the deceased alive on above (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Carroll D. Mahoney		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12-7-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Carroll D. Mahoney, M.D.		22e ADDRESS 10301 Georgia Ave. Silver Spring, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 12-11-79		23c NAME OF PLACE OF BURIAL OR CREMATION Forest Glen	
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A., Bethesda, Md.		23d LOCATION CITY OR TOWN Silver Spring		23e COUNTY Md.	
25a DATE REC'D. BY REGISTRAR DEC 14 1979		25b REGISTRAR'S SIGNATURE Notary M. Brady			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 1 3 7 4 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Margaret LYNN Price								12/27/79		2:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
FEMALE		WHITE		3 03 49		30 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
Texas		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
SILVER SPRING		HOLY CROSS HOSPITAL		WRITER							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
CALIFORNIA		LOS ANGELES		INGLEWOOD						500 EVERGREEN	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
LOWELL N. McCLUNG		MARGARET WHALEY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO		218-52-5610		LOWELL N. McCLUNG, 710 UNIV. BLVD., W., S.S., MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> 430 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Increased Intracranial Pressure</u> (c) <u>Ruptured Intracranial Aneurysm</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>26 Dec</u> 19 <u>79</u> , to <u>27 Dec</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>27 Dec</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Arthur P. Husted</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>28 Dec 79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ARTHUR P. HUSTED</u>		22e. ADDRESS <u>2141 K ST NW WDC</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		12/30/79		CRANE CEMETERY							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
John O. Durst		Oakland, Md.		JAN 2 1980				<u>Arthur P. Husted</u>			

BP _____

Q10

DATE

TIME

REPORT NO.

TEST NO.

TESTER

TEST DATE

TEST TIME

TEST LOCATION

TESTER

TEST DATE

TEST TIME

TEST LOCATION

TESTER

TEST RESULTS

TEST RESULTS

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Q10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA PROTZ			2a. DATE OF DEATH MONTH DAY YEAR 12/24/79		2b. HOUR 1:50 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DEC 3, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SLOVAKIA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY PRI. GEO	13c. CITY OR TOWN COLLEGE PARK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9014 RHODE ISLAND AVENUE	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT DAUGHTER ANNE M. ANZELONE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>atherosclerosis</u> (c) <u>30 years</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) (this hospital) attended the deceased from <u>July</u> 19 <u>77</u> to <u>Dec</u> 19 <u>79</u> , that (1) (we) last saw the deceased on <u>Dec 24</u> 19 <u>79</u> , and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.					
22a. SIGNATURE <u>Mark S Rosen</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 12/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark S Rosen, MD		22e. ADDRESS Silver Spring, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/27/79	23c. NAME OF CEMETERY OR CREMATORY ST SIMON AND JUDE		23d. LOCATION CITY OR TOWN COUNTY STATE BLAIRSVILLE -PA.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			25a. DATE REC'D. BY REGISTRAR DEC 26 1979		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

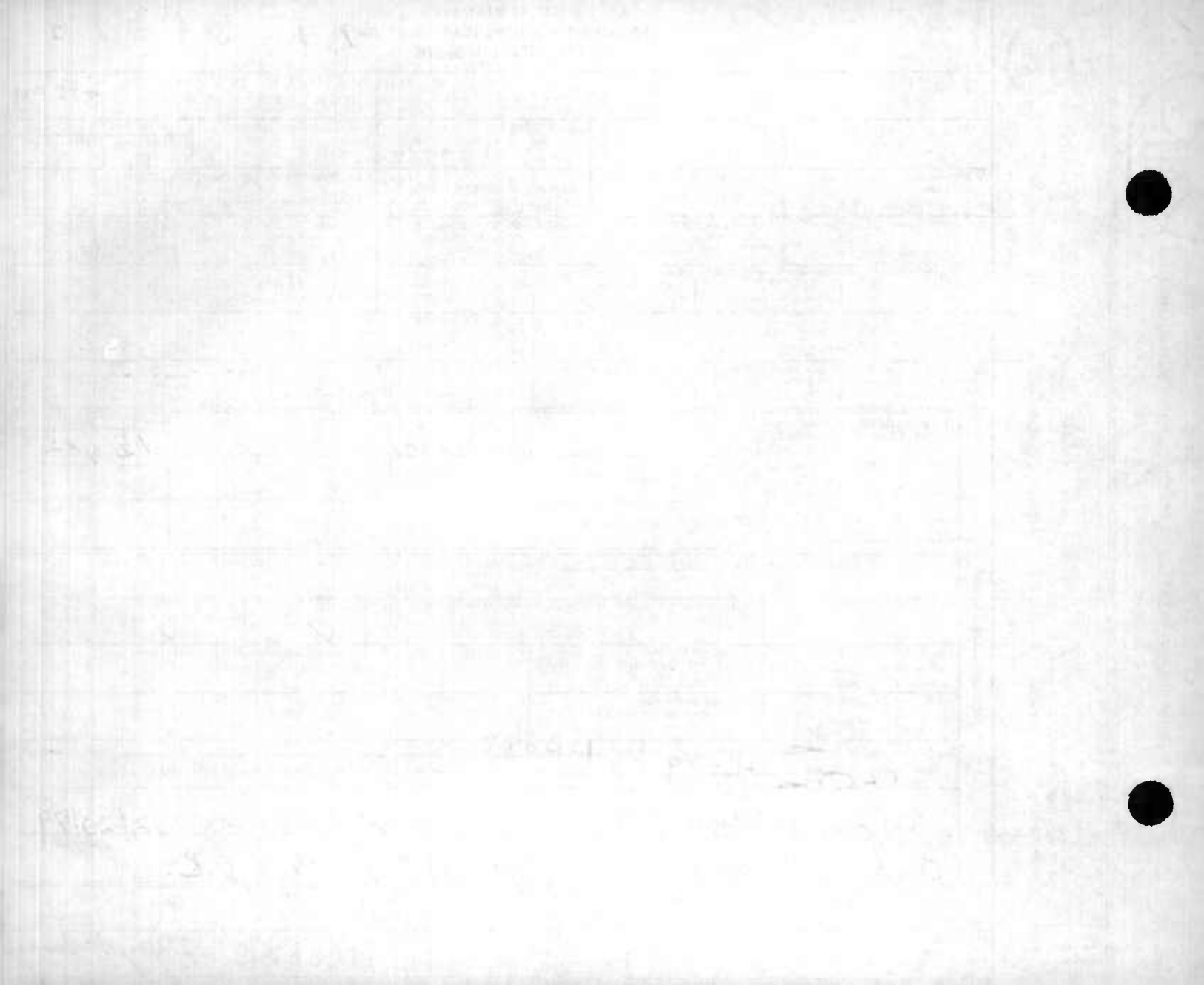
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward Mathews Quick			2a. DATE OF DEATH MONTH DAY YEAR Dec. 20, 1979			2b. HOUR PM 855 PM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 13 1967		6 AGE (IN YEARS LAST BIRTHDAY) 12		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) St. Louis, MO		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5611 Namakagen, Bethesda				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY St. Andrew's	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5611 Namakagen	
14 FATHER'S NAME FIRST MIDDLE LAST Harold Edward Quick, Jr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Colleen Mathews					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS Colleen M. Quick 5611 Namakagen Bethesda, MD 20016			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia 2089 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/20/79 , 19____, to____, 19____, that (I) (was) lost saw the deceased alive on 12/20/79 , 19____, and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above (I) (did) (did not) view the body after death.									
22b. SIGNATURE James Ramsey, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Ramsey						22e. ADDRESS 1145 19th St. Wash, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec 26 1979		23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wichita Kansas		
24 FUNERAL DIRECTOR NAME Pearson's F.H.			ADDRESS Falls Church, VA			25a. DATE REC'D. BY REGISTRAR DEC 26 1979			
				25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy					



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dorothy Cadelia Read			2a. DATE OF DEATH MONTH 13 DAY 26 YEAR 79			2b. HOUR 9¹² M				
3. SEX F		4. RACE Cauc		5. DATE OF BIRTH MONTH 04 DAY 26 YEAR 04		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7425 Democracy Blvd.	
14. FATHER'S NAME FIRST Joseph MIDDLE Milstead LAST 				15. MOTHER'S MAIDEN NAME FIRST Lucy MIDDLE Thompson LAST 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-34-3718		17. INFORMANT William T. Read ADDRESS 4218 Chestnut Street Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioblastoma multiforme Left temporal lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION 9/13/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Glioblastoma - L. temp. lobe				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 						
22a. I certify that (I) (this hospital) attended the deceased from April 19 79 to 12/26/79 , that (I) (we) lost saw the deceased alive on 12/23/79 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not see the body after death,)										
22b. SIGNATURE Earle B. Thompson MD				22c. DATE SIGNED 12/26/79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Earle B Thompson MD		
22e. ADDRESS 6111 Executive Blvd. Rockville, MD 20852				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 29, 79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum		23d. LOCATION CITY OR TOWN Brentwood COUNTY Prince Geo. STATE Md.				
24. FUNERAL DIRECTOR NAME Hines-Rinaldi Funeral Home ADDRESS 11800 New Hamp. Ave. S S 20904 Md.				25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE Leahy/Reg				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 1 3 7 8 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Harriet A. Reggio								12-14-79		4:50 P.M.	
3 SEX		4. RACE		5. DATE OF BIRTH MONTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		Oct. 8, 1925		54		YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Rockville		11002 Middleshire Place		Sec'y.		School					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md		Montg.		Rockville				11002 Middleshire Place			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Carl W. Buchheister				Harriet Gillilan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				081-20-1071		Louis C. Reggio		Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>										3 years	
DUETO, OR AS A CONSEQUENCE OF (b) <u>Alcoholism</u>										54 years	
DUETO, OR AS A CONSEQUENCE OF (c) <u>Heart</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>8-18-75</u> 19____, to <u>12-14-79</u> 19____ that (I) <u>examined</u> saw the deceased alive on <u>12-13-79</u> 19____, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If I was told (did not) view the body after death.											
22b. SIGNATURE OF PHYSICIAN						22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
B. Leonard B. B. M.D.						8630 FARMAN ST #230 Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Dec. 17, 1979		Gate of Heaven		Silver Spring, Md.					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.						DEC 20 1979					

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Received

General

USA

Rockville

Rockville

Carl E. Bachmiller

101-10-107 (only 2. 10/10/70)

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Dec 10 1970
Rockville, Md.
General
101-10-107 (only 2. 10/10/70)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 31379	
1. FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				2r. DATE OF DEATH				2b. HOUR			
IDA A. REHN				12-5-79				720 P.M.			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		4/13/1891		88		MONTHS		DAYS	
7r. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Penn.		U.S.A.				MONTGOMERY					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		SUBURBAN HOSPITAL				Housewife		Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13r. STREET ADDRESS			
Pa.		Butler		Butler		YES <input type="checkbox"/> NO <input type="checkbox"/>		R.D. 6			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Anton				Sophie Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
No				211-36-8153		Mrs. Betty Chambers		Chevy Chase Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4413 Rupture Abdominal aortic aneurysm											
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic vascular disease										48 hours	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21r. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from 12/4 1979, to 12/5 1979, that (I) (we) last saw the deceased alive on 12/5/79 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
M.D.										12-5-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22r. ADDRESS							
ALBERTO ROTSZTAIN				10401 Old Georgetown Rd. #305 Bethesda, Md. 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial				12-8-79		Greenlawn Burial Est.		Franklin Butler Pa.			
24 FUNERAL HOME NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Joseph Gawler sons Inc.				5130 Wisc. Ave. N.W. Washington D.C. 20016				DEC 1 1979		R. J. K. B. B. B.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 8 0

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE ALICE REICHART		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24 1979		2b. HOUR 0520A M	
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH SEPT 14 th 1924	
6 AGE (IN YEARS LAST BIRTHDAY) 55		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) HOMEMAKER	
12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POTOMAC	
14 FATHER'S NAME FIRST MIDDLE LAST SAMUEL NMN KLARR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN NEWMAN KLARR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 105-12-6889		17 INFORMANT ADDRESS STUART REICHART 11613 Toulone Dr. Potomac Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SEPTICEMIA 585- DUE TO, OR AS A CONSEQUENCE OF (b) Chronic renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 11 DEC 19 79, to 24 DEC 19 79, that (I) (we) last saw the deceased alive on 23 DEC 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE T. J. Spurling		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 24 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. J. SPURLING LTJMC, UNSR		22e. ADDRESS National Naval Medical Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-26-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Baldensburg, Maryland					
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		ADDRESS Rockville, Md.		25a. DATE REC'D. BY REGISTRAR JAN 2 1980	
25b. REGISTRAR'S SIGNATURE R. J. Spurling					

1816

valley land near

X

of the



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 3 8 1	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Laura — Rizzo		2a. DATE OF DEATH MONTH DAY YEAR December 31, 1979			2b. HOUR 8 AM		
3. SEX Female		4. RACE white		5. DATE OF BIRTH FEB. 22, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 93			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 17517 Queen Elizabeth Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY Mens Clothing Factory		
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 17517 Queen Elizabeth Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph — Sciarabba				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna — Buono							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 104-05-5674		17. INFORMANT ADDRESS E. Edward Rizzo Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pleural Effusion</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 days 2 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1977</u> to <u>Dec. 31, 1979</u> , that (II) (we) last saw the deceased alive on <u>Dec 27, 1979</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/31/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellert, MD.				22e. ADDRESS 18111 Prince Phillip Dr. Olney							
23a. BURIAL, CREMATION, REMOVAL REMOVAL		23b. DATE Jan. 1, 1980		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre			23d. LOCATION CITY OR TOWN STATE Rochester Monroe MD New York				
24. FUNERAL DIRECTOR NAME Francis H. Barber Laytonsville, Md. 20760						25a. DATE REC'D. BY REGISTRAR JAN 7 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Cleared with medical examiner: 12-26-79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST Craig Daniel Roberson					MONTH DAY YEAR 12 26 79				
3 SEX					2b. HOUR				
Male					8:00 AM				
4 RACE					5 DATE OF BIRTH				
White					MONTH DAY YEAR 11 22 74				
6 AGE (IN YEARS LAST BIRTHDAY)					7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				
5 YRS					Washington DC				
8. CITIZEN OF WHAT COUNTRY?					9 BALTIMORE CITY OR COUNTY OF DEATH				
USA					Montgomery MD.				
10 CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				
Olney					5318 Olney-Laytonsville Road				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE					13b. COUNTY				
Maryland					Montgomery				
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST David Melvin Roberson					FIRST MIDDLE LAST Charlotte Anne Wade				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
no					—				
17. INFORMANT					ADDRESS				
Charlotte A. Roberson					Mother-5318 Olney Laytonsville Rd				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)									
PART 1. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) respiratory arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) muscle weakness									
DUE TO, OR AS A CONSEQUENCE OF (c) metachromatic leukodystrophy									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
progressive neurological deterioration + associated muscle weakness									
19a. DATE OF OPERATION									
—									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
—									
20a. AUTOPSY?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY									
HOUR A.M. MONTH DAY YEAR 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
—									
21d. INJURY OCCURRED									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
—									
21f. LOCATION									
STREET CITY OR TOWN COUNTY STATE									
—									
22a. I certify that (1) (this hospital) attended the deceased from December , 19 74 , to Dec. , 19 79 , that (1) we lost saw the deceased alive on October , 19 79 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death.									
22b. SIGNATURE									
Dr. A. Pedreira									
DEGREE									
M.D.									
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. DATE SIGNED									
12-26-79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
FRANK A. PEDREIRA									
22e. ADDRESS									
19251 MONTGOMERY VILLAGE AVE., GAITHERSBURG, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
Burial									
23b. DATE									
Dec. 27, 1979									
23c. NAME OF CEMETERY OR CREMATORY									
Laytonsville									
23d. LOCATION									
CITY OR TOWN COUNTY STATE Laytonsville Mont. Md.									
24. FUNERAL DIRECTOR									
Francis H. Barber Laytonsville, Md. 20760									
25a. DATE REC'D. BY REGISTRAR									
DEC 28 1979									
25b. REGISTRAR'S SIGNATURE									
[Signature]									



RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY
JAN 10 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN ELIZABETH ROBERSON					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 12, 1979			2b. HOUR 12:15P M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 16, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH CLINICAL CENTER, BETHESDA, MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST J. WILLIAM HOWARD					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH HOLTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-12-1943		17. INFORMANT ADDRESS MR. HAROLD ROBERSON HUSBAND (SAME AS ABOVE)						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) hepatic failure 1719 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) widespread metastases from leiomyosarcoma DUE TO, OR AS A CONSEQUENCE OF (c) 28 months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 4, 1979 to DECEMBER 12, 1979 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on DECEMBER 12, 1979 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.										
22b. SIGNATURE Bruce A. Silver				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12/13/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce A. Silver				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION CITY OR TOWN COUNTY STATE FREDERICK MARYLAND		23e. DATE REC'D. BY REGISTRAR DEC 17 1979		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25a. DATE REC'D. BY REGISTRAR DEC 17 1979					

MEDICAL CERTIFICATION

U.S.A.

TEACHER

MONTGOMERY

WATER

ELLINGTON

HOWARD

WILLIAM

J.

100

PRODUCTION

MR. OLIVER

12/15/73
FARMER & COLLINS

ENTIRE

500 UNIV. BLVD. N. SILVER SPRING, MD. 20901 DEC 17 1973

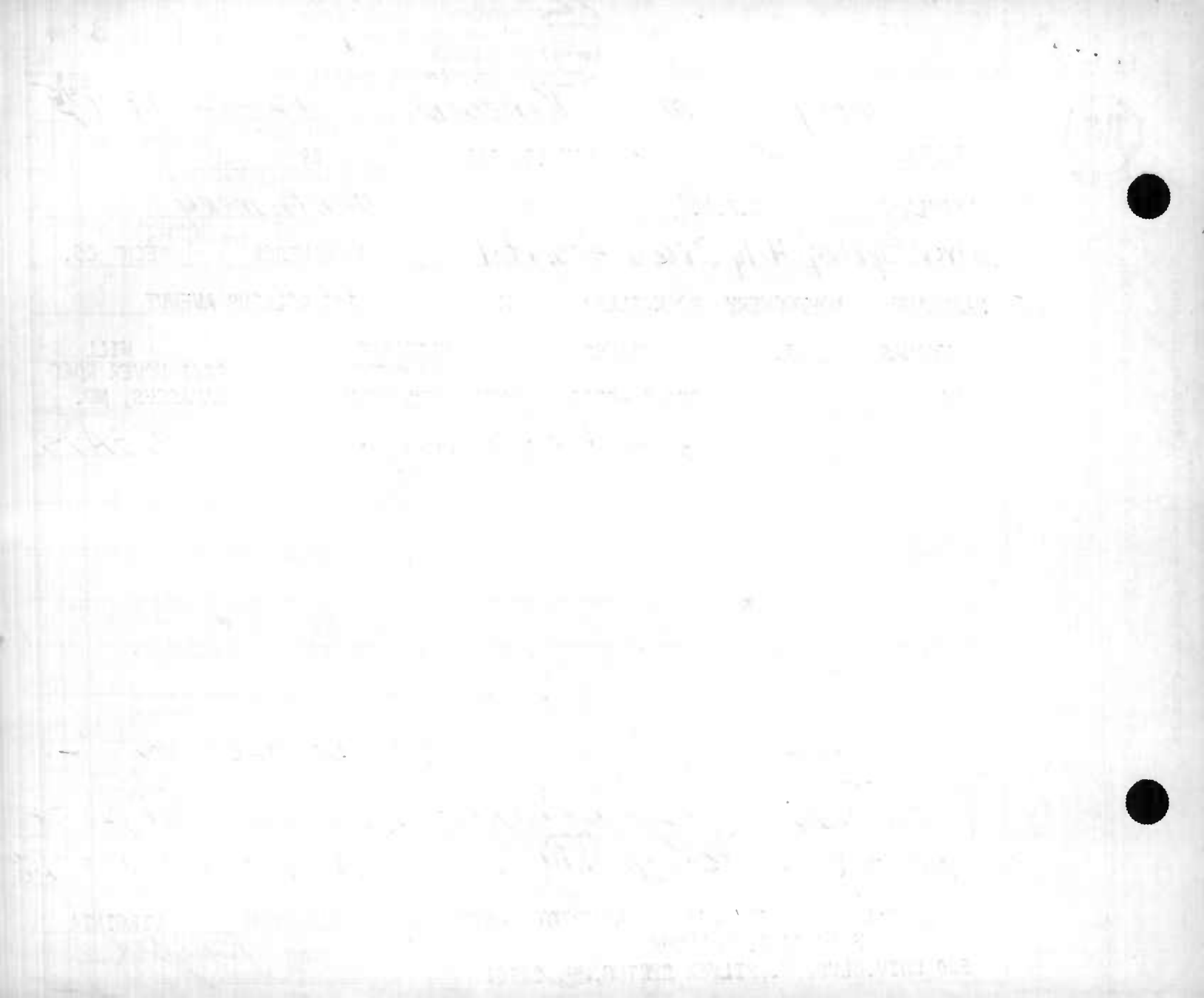


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 79 31384						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Mary M Robeson			2a. DATE OF DEATH MONTH DAY YEAR 12-25-79			2b. HOUR 9:45 AM
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 25, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY HECHT CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 199 ROLLINS AVENUE
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS J. GRAVES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH HILL			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-10-3985			17. INFORMANT DAUGHTER MARY HUNTZBERRY			ADDRESS 9841 MOVER ROAD DAMASCUS, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 485- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (my hospital) attended the deceased from 19 73 to 25 Dec 19 79, that (I) (myself) saw the deceased alive on 25 Dec 19 79, and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)									
22b. SIGNATURE Walter E. Goetz						DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 26 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOETZ MD						22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/28/79		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA		
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE H. J. McBrady	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 8 8539 1/3/80 83

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JEAN GRAHAM ROBINSON			2a. DATE OF DEATH MONTH DAY YEAR DEC 08 79			2b. HOUR 1945 PM				
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR SEP 02 12		6. AGE (IN YEARS LAST BIRTHDAY) 67		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXEC. SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY WHITE HOUSE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA					13b. COUNTY ARLINGTON		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN WALTER GRAHAM					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY MAHONEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 018-16-3927		17. INFORMANT ADDRESS HUNTER R. ROBINSON 1680 SOUTH EAST ST					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 2028 DUE TO, OR AS A CONSEQUENCE OF (b) COMPLICATED LYMPHOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE X <i>George T. Gamblin</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/9/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) X GEORGE T. GAMBLIN					22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Dec 10 79		23c. NAME OF CEMETERY BETHESDA MD 20814 Metropolitan Alexandria, Virginia					
24. FUNERAL DIRECTOR NAME Pearson's Funeral Home Falls Church					ADDRESS Virginia		25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCreedy</i>	

PHARMACY

CONFIDENTIAL BY PHONIA

NATIONAL NAVAL MEDICAL CENTER
BETHESDA, MD. 20814

X GEORGE T. CAMPBELL



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE 22a. Film#G539 1-24-80 FOR REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Jean Elizabeth Robison					12-20-79			10:28AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		White		January 10, 1925		54		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Montgomery MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General Hospital				Housewife		Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
13a. STATE CITY					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		915 Montgomery Street		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Charles E. Scott					Edna E. Fairall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no							Howard J. Robison same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cephalomalaria</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:									
(b) <u>Anoxia</u> (c) <u>Anaphylaxis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Hypertension</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			1:00 PM 12 14 79		Arterial dye injection				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		STATE
			Montgomery Hosp.				Mont.		Md.
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14/79</u> 19 <u>79</u> , to <u>12/20</u> 19 <u>79</u> , that (I) <u>do</u> lost saw the deceased alive on <u>12/19/79</u> , and that in my own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Natural</u>									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
HAROLD J. PASSES					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			20 Dec	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
HAROLD J. PASSES M.D.					4425 Montgomery Ave Bethesda Md 20014				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			Dec. 24, 1979		Ivy Hill Cemetery		Laurel, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
David J. H. [Signature]					10/11/1980		[Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Female

Wife

January 10, 1952

Married

USA

MA

PC

Law 1

x

State E. Taitai

Charles E. Scott

Robert J. Robinson same as above

no



Serial

Dec 24, 1952

Ivy Hill Cemetery

Laurel, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						7 9 3 1 3 8 7					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eileen E. Roell-Goemans						2a. DATE OF DEATH MONTH DAY YEAR December 21, 1979				2b. HOUR 12:55 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 6, 1926		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TURKEY		7b. CITIZEN OF WHAT COUNTRY? HOLLAND		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH Clinical Center, Bethesda, MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Washington, DC						13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2732 34th St., NW 20007	
14. FATHER'S NAME FIRST MIDDLE LAST HENDERIK - GOEMANS						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLADYS G. SHOTT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-98-0397		17. INFORMANT Mr. Eric Roell, Husband (same as above)							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>electrolyte abnormalities</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>small bowel cancer</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <u>1830</u> <u>4 days</u> <u>16 months</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>small bowel obstruction; infection</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 17, 1979</u> to <u>December 21, 79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 21, 79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (Type) (did) <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <u>J.K. Tobacman MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-21-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.K. Tobacman MD						22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, MD 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12-22-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR NAME DeVol Funeral Home Robert A. DeVol						24b. ADDRESS 2222 Wisc. Ave. Washington D.C.		25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE <u>Robert A. DeVol</u>	

BP



REAR MOTOR

REAR MOTOR



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- STATE REGISTRAR		REG. NO. 31388									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Natalie Piowarchik Romanofsky								DATE ESTIMATED <input checked="" type="checkbox"/> 12/31 1979		8:30 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Female	White	Aug. 22, 1890		89 YRS.						12/31 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Russia		USA				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		13602 Krushner Court				Maintenance		Consolidated			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		13602 Krushner Court Edison			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
John Piowarchik				Anastasia Matweichik							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		13602 Krushner Court					
No		069-01-7013		Ann Munson		Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
None											
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR		P.M. 19		None					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
<i>John S. Rogers</i>		M.D. Deputy		12/31/79							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
John S. Rogers, M.D.		1919 Seminary Road Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		Jan, 3, 80		St. Vladimir Cemetery		Cassville, New Jersey					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hines/Rinaldi Funeral Home		11800 New Hampshire Ave., Silver Spring, Md.		JAN 4 1980		<i>John S. Rogers</i>					





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 3 8 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ISIDORE ROMOFF		2a. DATE OF DEATH MONTH DAY YEAR Dec. 12, 1979		2b. HOUR 1:30p M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct 20, 1888	6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retailer	12b. KIND OF BUSINESS OR INDUSTRY Textiles
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE Maryland	13b. COUNTY Montg.	13c. CITY OR TOWN Sil Spg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1400 Fenwick Lane
14. FATHER'S NAME FIRST MIDDLE LAST Abram Romoff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Rosenthal		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 076-28-7699	17. INFORMANT ADDRESS Rena Zalosh; 12302 Downer Dr., SSpG, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>? MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROSIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hour</u> <u>? week</u> <u>? years</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PULMONARY INFECTION</u>				
19a. DATE OF OPERATION 12/8/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Atrio-Ventricular Dissection		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12/8/79</u> to <u>12/12/79</u> , that (I) (we) last saw the deceased alive on <u>12/12/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>Sol Shaz</u>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-13-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SOL SHAZ, M.D.		22e. ADDRESS 4805 Bel Air Rd, Rockville, Md 10301 Georgia Avenue, Sil Spg., Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-13-79	23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Md.				
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

THE UNIVERSITY OF CHICAGO
LIBRARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7931390					
FOR 1- STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sadye Rosenberg				2a. DATE OF DEATH MONTH DAY YEAR 12-11-79				2b. HOUR 11 P.M.							
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 19 98		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.									
10. CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement + Nursing				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1220 BLAIR MILL ROAD									
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN SCHWARTZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE (UNKNOWN)											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 099-09-2844D		17. INFORMANT ADDRESS MRS. RUTH MARGIN, 1220 BLAIR MILL ROAD, SILVER SPRING, MARYLAND											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 5305 DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal Spasm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Cerebral Arterio Sclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 6 months 2 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
MEDICAL CERTIFICATION															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 12/6/79 to 12/11/79, that (1) (we) last saw the deceased alive on 12/6/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Morton W. Shapiro				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/11/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton W. Shapiro				22e. ADDRESS 5225 Poole Hill Rd Beltsville											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/13/1979		23c. NAME OF CEMETERY OR CREMATORY UNITED HEBREW CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE STATEN ISLAND NEW YORK							
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.												25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

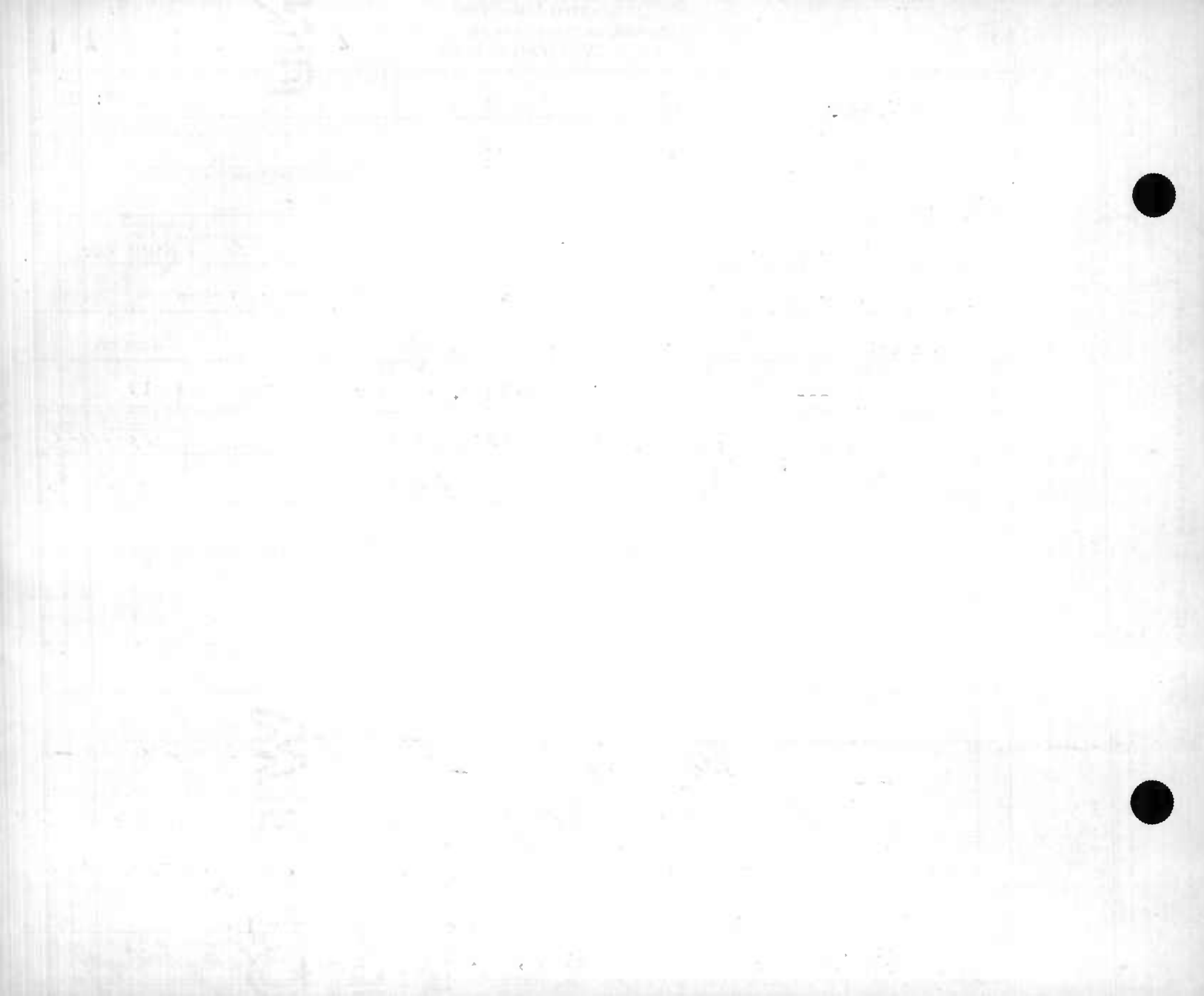


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

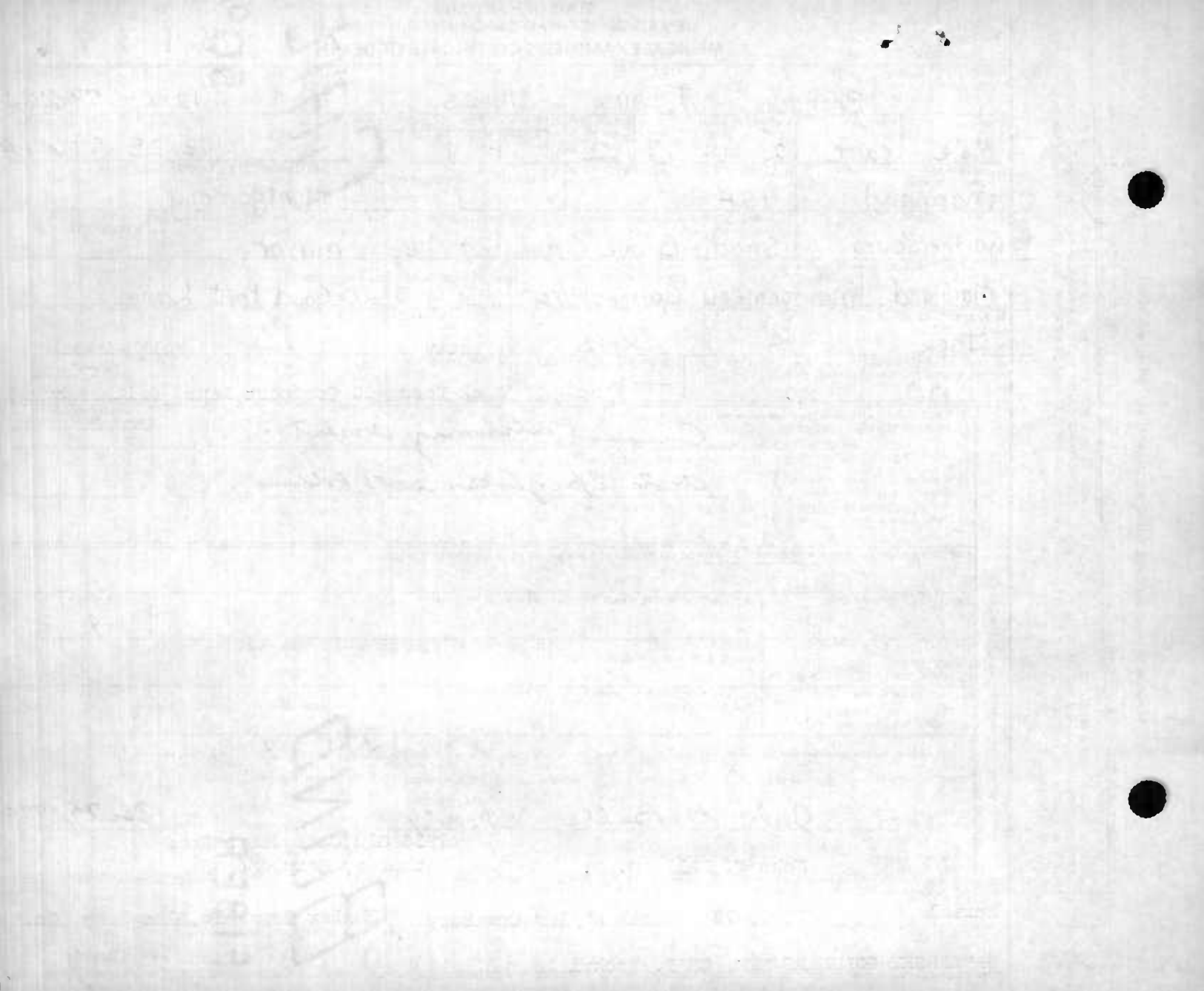
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 3 9 1	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) REBECCA JULIA C. ROSE			2a. DATE OF DEATH MONTH DAY YEAR 12 05 79			2b. HOUR 9:40A M					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 06 99		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW HAMPSHIRE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk		12b. KIND OF BUSINESS OR INDUSTRY Navy Yard			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY PG		13c. CITY OR TOWN SUITLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3523 Terrace Drive		
14. FATHER'S NAME FIRST MIDDLE LAST Michael Daley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---			17. INFORMANT (daughter) ADDRESS Paula W. Windsor Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 1749 DUE TO, OR AS A CONSEQUENCE OF (b) CANCER OF BREAST DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS 3 YRS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 28 NOV 19 79 to 5 DEC 19 79, that (I) (we) lost saw the deceased alive on 4 DEC 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Walter E. Goetz MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5 DEC 79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOETZ MD						22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7 Dec 1979		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wrightsville Penna				
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home Inc						ADDRESS Suitland, Md.		25a. DATE REC'D. BY REGISTRAR DEC 11 1979			
						25b. REGISTRAR'S SIGNATURE R. H. McBratney					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9 3 1 3 9 2	
1. DECEASED NAME (TYPE OR PRINT) Brandon Joshua Ross							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 25 19 79		2b. HOUR 6:16A		
3. SEX Male	4. RACE cauc	5. DATE OF BIRTH MONTH DAY YEAR 2 14 77	6. AGE (IN YEARS) LAST BIRTHDAY 2 YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-25 19 79		2d. HOUR 6:16A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) minor		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20 Good Port Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Jack A Ross			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty ---- Fellheimer			16. ADDRESS Maryland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. None		17. INFORMANT Jack Ross, 20 Goodport Lane, Gaithersburg,					
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordis Pulmonary arrest. 4643 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Acute Epiglottitis with edema. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy				DATE SIGNED Dec 25, 1979			
EXAMINER'S NAME (TYPE OR PRINT) John G. BALL, M. D.				ADDRESS Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-28-79		23c. NAME OF CEMETERY OR CREMATORY Beth Shalom Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Shaler Township, Allegheny, Pa.			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.				ADDRESS				25a. DATE REC'D. BY REGISTRAR JAN 1 1980		25b. REGISTRAR'S SIGNATURE History McBrady	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9 31393	
1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH						MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		12-25 1979		9 AM	
Ann Ervin Royster											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
female		white		Sept 17, 1896		83 YRS.		MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. HOUR	
North Carolina		U. S. A.		WIDOWED		DIVORCED		Montgomery MD.		12 PM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		6621 Michaels Dr.		Homemaker		own home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Bethesda		YES X NO		6621 Michaels Drive			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Lucian Hanks Ervin		Annie Brown		no		215-52-6834		Patsy r. Lozupone		7903 Greentree Road Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
PART 1 DEATH WAS CAUSED BY:						YES NO X					
IMMEDIATE CAUSE (a) 4292 Coronary Insufficiency Acute.											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) Cardiovascular Disease.											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection	
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		death resulted from:		Inquiry		and in my opinion	
21g. CITY OR TOWN		21h. COUNTY		21i. STATE		Natural causes X Accident Suicide Homicide Undetermined manner					
22a. ACTUAL SIGNATURE		22b. EXAMINER'S NAME (TYPE OR PRINT)		22c. DATE		22d. NAME OF CEMETERY OR CREMATORY		22e. LOCATION		22f. COUNTY	
John G. Ball		John G. Ball		12-26-79		Cedar Hill Crematory		Suitland, Prince Georges, Md.		22g. DATE REC'D BY REGISTRAR	
22h. FUNERAL DIRECTOR NAME		22i. DATE		22j. REGISTRAR'S SIGNATURE		22k. DATE		22l. COUNTY		22m. STATE	
Joseph Gawler's Sons, Inc.		12-26-79		DEC 28 1979							
5130 Wisconsin Ave., N. W., Washington, D. C.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 3 9 4	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSALIE DELANA RUSSELL						2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 15, 1979				2b. HOUR 0150 A M	
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR DEC 26 20		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS		7a. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD					
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W. VIRGINIA						13b. COUNTY BERKELEY		13c. CITY OR TOWN MARTINSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST EUGENE MELVIN RUSSELL						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSILIE DELANNA RUBIN SPONG					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 579-05-1857		17 INFORMANT DAUGHTER BARBARA A. VARNEY		ADDRESS 1316 HONEYSUCKLE LN CHARLESTON, S.C. 29412			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 METASTATIC INFILTRATING DUCTAL CARCINOMA OF THE BREAST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Chris K. Fenton, LT, MC, USNR FOR JEP DEGREE CRANE, LT, MC, USNR ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										22c. DATE SIGNED 16 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRIS K. FENTON						22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/19/79		23c. NAME OF CEMETERY OR CREMATORY REFORMED CHURCH GRAVEYARD			23d. LOCATION CITY OR TOWN COUNTY STATE SHEPARDSTOWN, W. VIRGINIA			
24 FUNERAL DIRECTOR M. J. STRIDER FUNERAL HOME/CHARLESTON, W. VA.						25a. DATE REC'D. BY REGISTRAR DEC 19 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

BP _____

RECEIVED 10/10/10



RECEIVED 10/10/10

10/10/10
10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					7 9 3 1 3 9 5						
1. DECEASED NAME (TYPE OR PRINT) Rebecca SACHS					2a. DATE OF DEATH MONTH DAY YEAR 12 31 79						
3 SEX FEMALE		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 24 92		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7b. HOUR 8:10 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) District/Columbia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE D. C.		13b. COUNTY N/A		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4201 Cathedral Ave., N. W.			
14 FATHER'S NAME FIRST MIDDLE LAST David --- Krupsaw					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara --- ---						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO Unknown		17 INFORMANT ADDRESS Washington, D. C. William Sachs, 4201 Cathedral Ave., N. W.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio Vascular Dis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min. 10 YRS 25 YRS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 59 to 12-31 1979, that (I) (we) lost the deceased alive on 12-27 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Marvin Fuchs MD					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-31-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN FUCHS MD					22e. ADDRESS 5315 Connecticut Ave NW DC						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-2-80		23c. NAME OF CEMETERY OR CREMATORY Ohev Sholom Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.					
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Mem. Chap., Rockville, Md.					24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 7 1980			25b. REGISTRAR'S SIGNATURE [Signature]	

Case 15

ED



[Faint, illegible text, likely bleed-through from the reverse side of the page.]



Item 22a G540 2/22/80 31396

FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE
1- STATE REGISTRAR
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jason Wade Savary			2a. DATE KNOWN OF DEATH ESTIMATED 12 20 19 79			2b. HOUR M			
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 23, 1976	6. AGE (IN YEARS LAST BIRTHDAY) 3 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 12 20 19 79			2d. HOUR 12:45 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 School Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11 School Drive	
14. FATHER'S NAME FIRST MIDDLE LAST John P. Savary				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teresa Mullins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS 1114 Viers Mill Rd. Calvert J. Savary Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke inhalation & Thermal injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR X M. MONTH DAY YEAR 12:15 M. 12 20 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) house fire				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11 School Drive, Gaithersburg, Mont, MD				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE 			TITLE (SPECIFY) Assistant MEDICAL EXAMINER					DATE SIGNED 12/21/79	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St. Balto., MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 24, 1979		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Md.		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A.			ADDRESS Rockville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE 		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



May 22, 1957

John F. Kennedy School

Secretary

John F. Kennedy

Handwritten signature

Robert F. Kennedy
New York, N.Y.

BP

DHMH-17
(VR A15 ME (5))
15M 7/76

Item 22a G540 2/22/80		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		31397	
1- STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		
Joseph Wayne Savary			XX MONTH DAY YEAR 12 20 19 79		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	White	Mar. 23, 1976	3 YRS.	MONTHS DAYS HOURS MIN	MONTH DAY YEAR 12 20 19 79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Md.		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Gaithersburg		11 School Drive		None	
13a. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Montg. Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
John P. Savary			Teresa Mullins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT
No			None		1114 Viers Mill Rd. Calvert J. Savary Rockville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Smoke inhalation and thermal injuries					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		12:15 A.M. 12 20 19 79		house fire	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		home		11 School Drive Gaithersburg, Mont., Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon		Assistant		12/21/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Ann M. Dixon, M.D.		111 Penn St. Balto, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Dec. 24, 1979		Parklawn Cem.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes, P.A.		DEC 27 1979		[Signature]	
26. LOCATION (CITY OR TOWN)		27. STATE			
Rockville, Md.		MD.			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

0520-4125/90/0000-0000\$01.00/0

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31398

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Phillip John Savary							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	White	Nov. 8, 1978	1 YRS			12 20 19 79	12:45 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	USA				Montgomery County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg	11 School Drive		None		None		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Md.	Montg.	Gaithersburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	11 School Drive			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
John P. Savary		Teresa Mullins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		None		1114 Viers Mill Rd. Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Acute carbon monoxide intoxication</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) _____							
DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		2:15 M. 12 20 19 79		house fire			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
		home		11 School Drive, Gaithersburg, Mont., Md.			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
Margarita A. Korell		Assistant		12/21/79			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Margarita A. Korell, M.D.		111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		Dec. 24, 1979		Parklawn Cem.		Rockville, Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes, P.A.		Rockville, Md.		DEC 27 1979		[Signature]	

BP

DHMH - 17
(VR A15 ME (5))
15M7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



177.3.10.1

USA

11 School Drive

California

U.S.

Savary

John

Home

No

Calvert A. Savary

1114 First St.

Rockville

Dec. 14, 1979

Robert A. [unclear] Funeral

Rockville, Md.

Encl:

James, E.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.
IMPORTANT: If item 21 is checked or item 18 is marked, the funeral director must notify the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 3 9 9			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE A. SAYLOR				2a. DATE OF DEATH MONTH DAY YEAR 12 23 79		2b. HOUR 5:49 AM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR June 25, 1899		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Safety Engr.		12b. KIND OF BUSINESS OR INDUSTRY Insurance	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN Md. Montg. Bethesda				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 5506 Glenwood Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Albert Saylor				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mengel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO WW I 181-09-8286		17 INFORMANT ADDRESS A Margaret S. Saylor Same as 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4146 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Duodenal ulcers</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 5 yrs. 5 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> 19 <u>65</u> , to <u>12/23</u> 19 <u>79</u> , that (I) (we) lost the deceased alive on <u>12/21</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John E. Everett				DEGREE MD		22c. DATE SIGNED 12/23/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN E. EVERETT				22e. ADDRESS 9460 Conn Av Kensington Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 24, 1979		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crema.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.	
24 FUNERAL DIRECTOR NAME Robert A. Humphrey Homes, P.A. Bethesda, Md.				25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

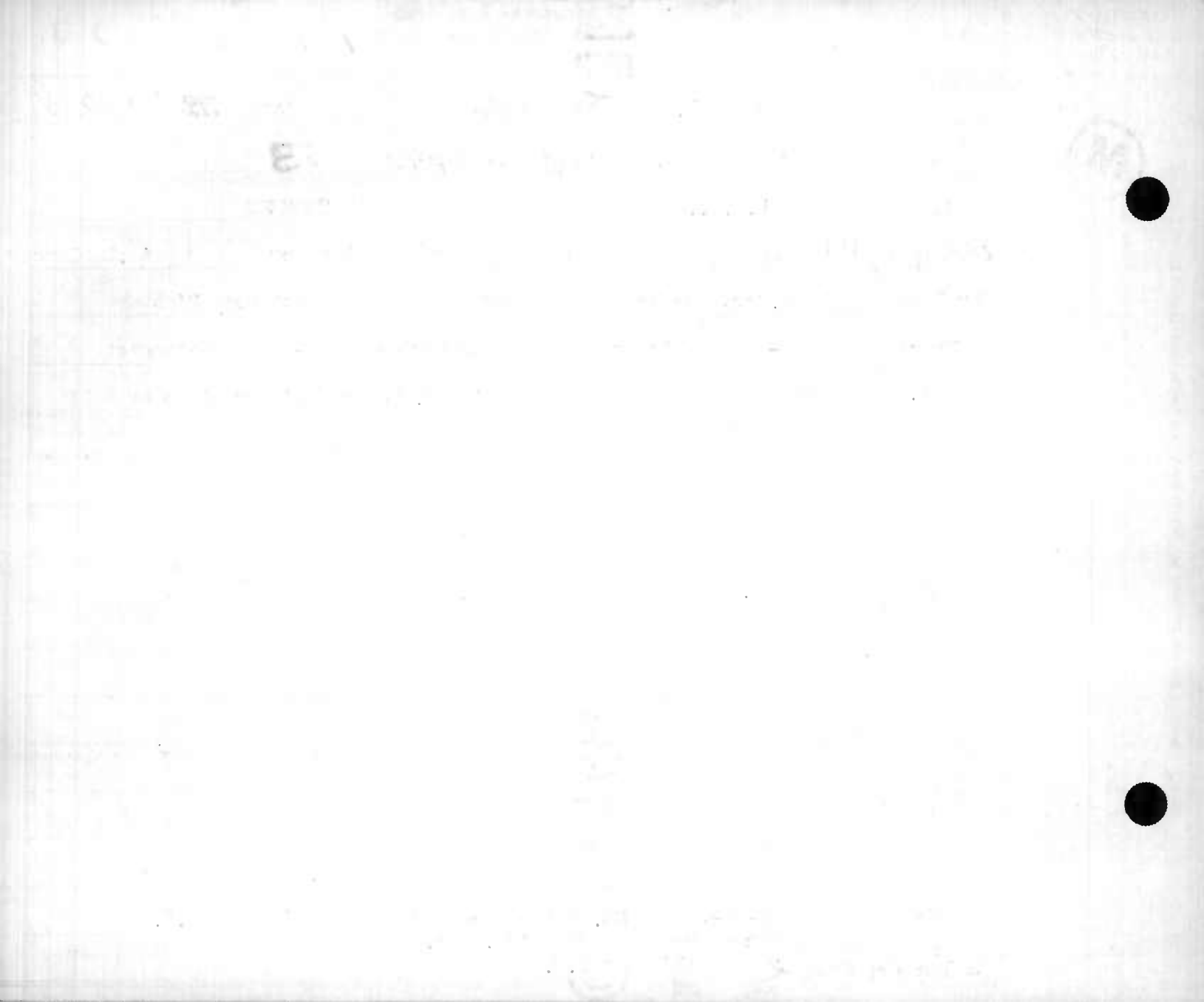
FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 0 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward H. Schirmer			2a. DATE OF DEATH MONTH DAY YEAR 29 DEC 79			2b. HOUR 1220 AM					
3. SEX Male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPT 4 1916		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Kensington, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Grinders Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffer		12b. KIND OF BUSINESS OR INDUSTRY Pvt. Employee			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4400 East West Highway		
14. FATHER'S NAME FIRST MIDDLE LAST Henry - Schirmer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine - Natengast							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW1		17. INFORMANT ADDRESS Louise G. Hawley/ Sister/ Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Cancer of Prostate 185- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive Heart Failure. Gastrointestinal Bleeding											
19a. DATE OF OPERATION 1976		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CANCER OF PROSTATE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 1976 , to 12/29 , 19 79 , that (1) (we) lost saw the deceased alive on 12/15 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.											
22b. SIGNATURE Ralph M. Coan M.D.				DEGREE M.D.				22c. DATE SIGNED 12/29/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH M. COAN M.D.				22e. ADDRESS 4400 EAST WEST HWY BETHESDA, MD 20014							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-79		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24. FUNERAL DIRECTOR NAME DeVol Funeral Home ADDRESS 2222 Wisc. Ave. Washington D.C.				25. DATE REC'D. BY REGISTRAR JAN 4 1980		25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 0 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Walter Schleier			2a. DATE OF DEATH MONTH DAY YEAR 12 23 79			2b. HOUR 12 31 PM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Upholster		12b. KIND OF BUSINESS OR INDUSTRY Furniture		
13a. STATE Maryland			13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4710 Bethesda Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST Bernard Schleier			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Stark			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 579-58-1495			17 INFORMANT ADDRESS Rockville, Md.			17b. Sonia Schleier; 1719 Lorre Dr.,				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ventricular fibrillation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) myocardial infarction	
		(c) coronary heart disease	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-15 , 19 79 , to 12-23 , 19 79 , that (I) (we) last saw the deceased alive on 12-23 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas G. Sinderson, MD				DEGREE MD		22c. DATE SIGNED 12-23-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON				22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE Md. 20852			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-79		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park Falls Church, Fairfax, Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR 12 28 1979			

10/16/61



10/16/61

10/16/61

10/16/61

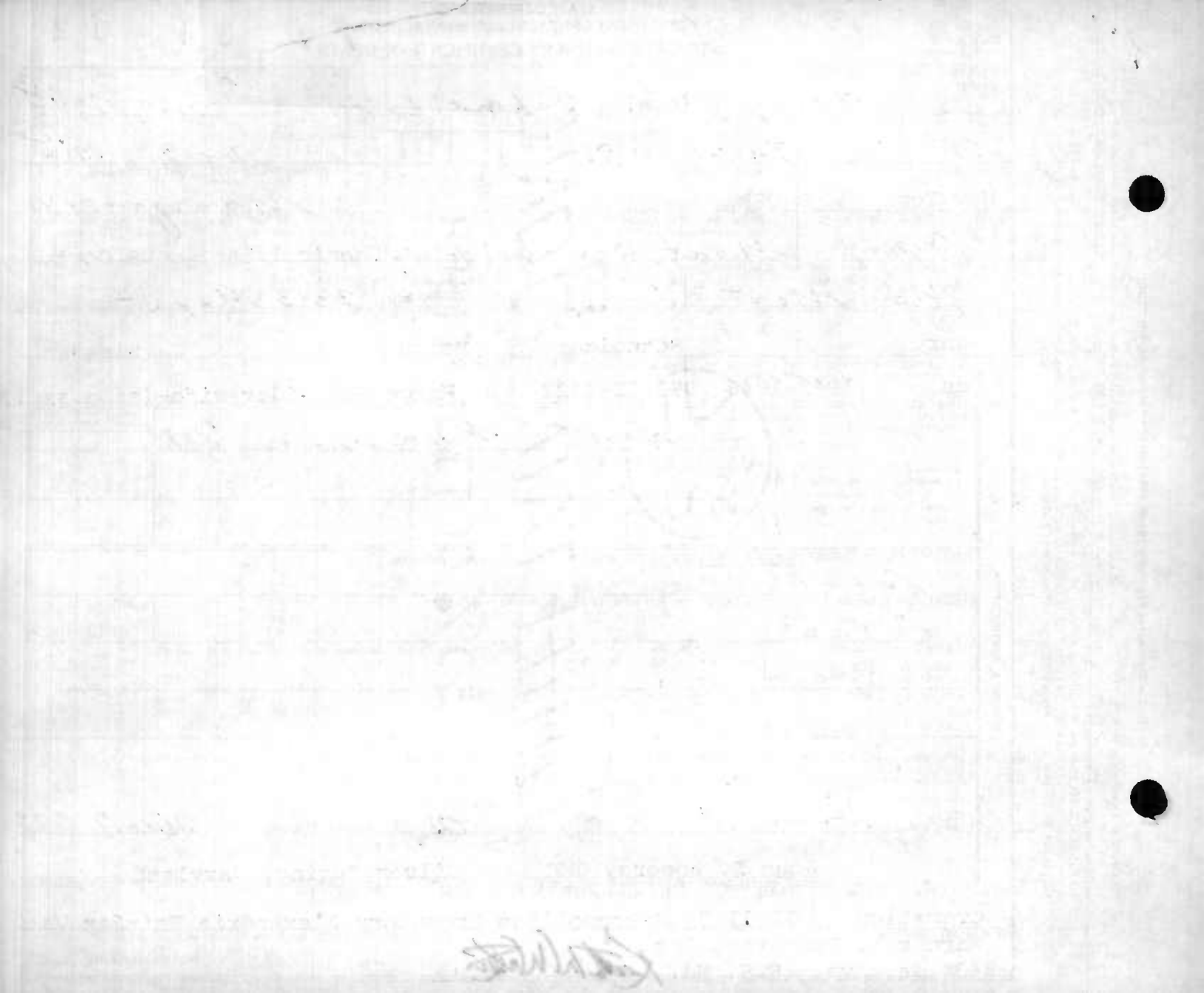
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10/16/61

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												9 31402 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) HARRY (nmn) SCHNEIDER												2a. DATE KNOWN OF DEATH ESTIMATED Dec 9 1979				2b. HOUR 11:45 P. M.											
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR June 5 21 5P YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD Dec 9 1979 P. M.				2d. HOUR 11:45 P. M.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.															
10. CITY OR TOWN OF DEATH Glen				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemical Eng.				12b. KIND OF BUSINESS OR INDUSTRY US Govt.															
13a. STATE Md				13b. COUNTY Mont				13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 3313 May St											
14. FATHER'S NAME FIRST MIDDLE LAST Henry Schneider				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Zinsser																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 1943-1946 071-12-4322				17. INFORMANT D. Madge Schneider-wife-(same as 13)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> 4391 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE John S. Rogers, DME				TITLE (SPECIFY) MEDICAL EXAMINER								DATE Dec. 9 1979															
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME				ADDRESS Silver Spring, Maryland																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12-11-79				23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Va.															
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. DATE REC'D. BY REGISTRAR DEC 13 1979				25b. REGISTRAR'S SIGNATURE H. J. McCurdy																			
8434 Ga. Ave., S.S. Md.																											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

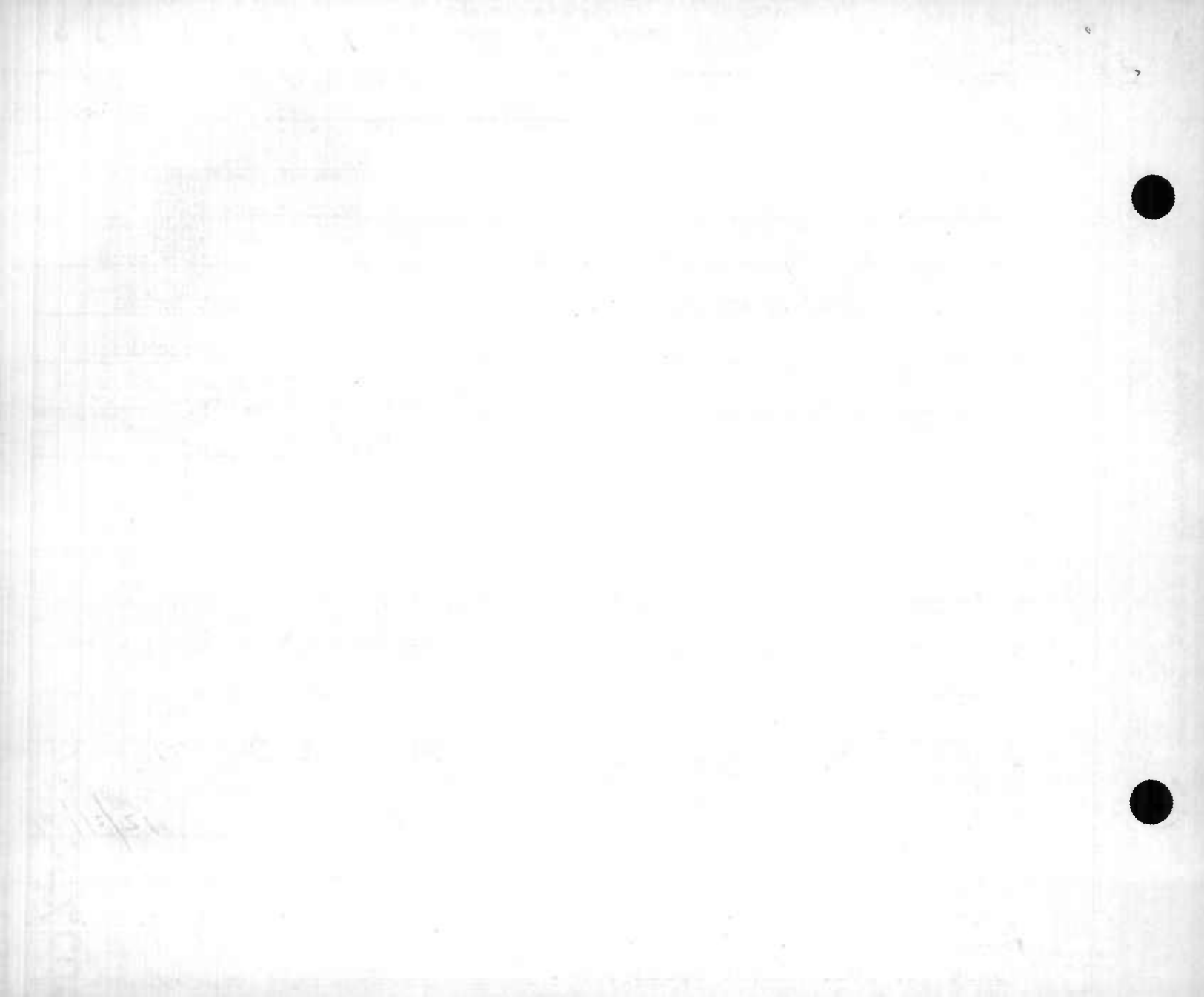
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by Dr. J. Rogers, Dep. Med. Ex. 1501

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 4 0 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) William Earl Schrider				2a. DATE OF DEATH MONTH DAY YEAR Dec. 21 1979		2b. HOUR 1:30 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 504 Northwest Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker		12b. KIND OF BUSINESS OR INDUSTRY Bakery	
13a. STATE Maryland		13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 504 Northwest Drive	
14. FATHER'S NAME FIRST MIDDLE LAST John T Schrider		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara J Hutchison		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO 578-09-6656		17. INFORMANT Mary Sabell Silver Spring		ADDRESS 504 Northwest Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of the Prostate 185- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1970 to 21 Dec 1979 , that (I) (we) lost saw the deceased dying on Oct 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Ira Tublin		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/21/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ira Tublin, MD.		22e. ADDRESS 8830 Cameron Street, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-79		23c. NAME OF CEMETERY OR CREMATORY Et. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg Pr. Geo. Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey		ADDRESS 8434 Ga. Ave. Silver Spring, Md.		25a. DATE REC'D BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE John J. McCurdy	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 4 0 4					
1. FOR STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Evelyne M. Sciambi								DEC. 19-1979					405 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		Aug. 8, 1923		56		MONTHS		DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		USA				Montgomery MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Kensington		Kensington Gardens Nursing Home								Secretary		US Govt.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1001 Rockville Pike Apt. 1016							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST				FIRST MIDDLE LAST											
Frank Hale				Lula Baird											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT							
No				579-22-8896				10824 Martin Redmon Drive Richard K. Sciambi Great Falls, Va. 22066							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA												6 months			
1629 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA, LUNG												18 "			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
DUE TO, OR AS A CONSEQUENCE OF (c) -															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from July 1978 to 12/19/79, that (I) (we) last saw the deceased alive on 12/11/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.															
22b. SIGNATURE												DEGREE		22c. DATE SIGNED	
Thos G. Ward MD														12/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS			
Thos G. Ward, 6116 Robinwood, Bethesda, MD 20034															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				Dec. 21, 79		Cedar Hill Cemetery				Suitland, Prince Geo. Md.					
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md.												DEC 20 1979		[Signature]	

Dec 19 1930

Dec 20 1930

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 9 31405

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CATHERINE A. SCOTT										2a. DATE KNOWN OF DEATH EST. MONTH DAY YEAR 12 24 79		2b. HOUR 4:28 AM	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Sept 23 62		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 17		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Dec. 24 1979		2d. HOUR 4:28 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Japan				7b. CITIZEN OF WHAT COUNTRY? (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U.S. Citizen				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD			
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY School	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7704 Granada Drive					
14. FATHER'S NAME FIRST MIDDLE LAST James D. Scott						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice Martus							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. Not Avail.		17. INFORMANT ADDRESS James D. Scott (Same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries. Severe.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Trauma from Auto Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:30am 12-24-79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Road control of Auto - Struck by car in the line</u>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Highway</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>7000 Block Barclay Blr. Bethesda, Mont Md.</u>							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE <u>John E. Ball</u>				TITLE (SPECIFY) <u>Deputy</u>				MEDICAL EXAMINER				DATE SIGNED <u>Dec. 24, 1979</u>	
EXAMINER'S NAME (TYPE OR PRINT) Old Georgetown Rd.				ADDRESS Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12-27-79		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Md.			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR JAN 2 1980				25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 4 0 6		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie P Selby				2a. DATE OF DEATH MONTH DAY YEAR 12 14 79		2b. HOUR 50 M			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 05 10 13		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
12. CITY OR TOWN OF DEATH Silver Spring		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15. STREET ADDRESS 1317 MIDWOOD PLACE	
16. FATHER'S NAME FIRST MIDDLE LAST John - Peters				17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen - O'Rourke					
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. 212-07-1188		19. INFORMANT ADDRESS Dr. George D. Selby 1317 Midwood Place, Silver Spring, Md.					
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PARKINSONISM</u> 3320 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>MENTAL DEPRESSION</u>									
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				22a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
24a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		24b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		24c. LOCATION STREET CITY OR TOWN COUNTY STATE					
25. I certify that (a) (this hospital) attended the deceased from <u>JUNE</u> 19 <u>76</u> , to <u>DEC 14</u> 19 <u>79</u> , that (b) (we) last saw the deceased alive on <u>12/14/79</u> 19 <u>79</u> , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (we) did (did not) view the body after death.									
26a. SIGNATURE <u>James A. Roberts, M.D.</u>				26b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				26c. DATE SIGNED 12/14/79	
27a. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES A. ROBERTS, M.D.</u>				27b. ADDRESS <u>8907 GARCIA AVE. SILVER SPRING, MD.</u>					
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		28b. DATE <u>Dec. 15, 79</u>		28c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		28d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington</u>			
29. FUNERAL DIRECTOR <u>Gartner-Sandison F.M.</u>				30. ADDRESS <u>316 E. Diamond Avenue, Gaithersburg, Md. 20760</u>		31. DATE RECEIVED BY REGISTRAR <u>DEC 19 1979</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 3 1 4 0 7 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Mable Polina Sencindiver		2a DATE OF DEATH MONTH DAY YEAR Dec. 25 1979		2b HOUR 3:30 A.M.	
3 SEX F	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR Jan. 14 1897		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS. <input type="checkbox"/> IF UNDER 1 YEAR MONTHS DAYS <input type="checkbox"/> # UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Gaithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman Wilson Health Care Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) R.N.		12b KIND OF BUSINESS OR INDUSTRY Nursing
13a STATE md.		13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 201 Russell Ave.
14 FATHER'S NAME FIRST MIDDLE LAST John Lewis Sencindiver		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTIE LEE DAVIS			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO 234-01-6091A		17 INFORMANT ADDRESS Mrs. Charles Sencindiver-Rt. 2, Inwood, WV	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of breast					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 YRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) under breast metastases					
(c) Generalized arteriosclerosis, Chronic organic brain syndrome					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK HOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 12/20/79 to 12/25/79 , that (I) (we) last saw the deceased alive on 12/20/79 and that (I) (we) (did not) view the body after death.					
22b SIGNATURE Nancy C. Strickland		DEGREE MD		22c DATE SIGNED 12/25/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Henry C. Strickland MD		22e ADDRESS 5413 Cedarhane Bethesda Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12-28-79		23c NAME OF CEMETERY OR CREMATORY Tuscarora Cemetery	
23d LOCATION CITY OR TOWN Berkeley West Virginia		COUNTY Berkeley		STATE West Virginia	
24 FUNERAL DIRECTOR NAME Charles M. Brown		ADDRESS 327 W. King St. Martinsburg, W. Va.		25a DATE REC'D. BY REGISTRAR DEC 28 1979	
25b REGISTRAR'S SIGNATURE Regina M. Brown					

10 21 01

Johns Hopkins University

Mrs. Charles Gendinver-11, In-00,

11-23-72
Brown Funeral Home, Washington, D.C.
11-23-72

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 4 0 8 REG. NO.			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Caridad A. Sevilla					December 13 79					7:34p M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 19 1915		6. AGE (IN YEARS LAST BIRTHDAY) YRS 64		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dominican Rep.		7b. CITIZEN OF WHAT COUNTRY? Dominican Rep.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.				13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1258 Pleasant St. South East			
14. FATHER'S NAME FIRST MIDDLE LAST Jose Aponte					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Epiphinia Rodriguez								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 579-52-8574B		17. INFORMANT ADDRESS Januario Sevilla, See Item 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure 4416 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION Dec. 13, 1979			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Aneurism				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from Nov. 30 19 79 to Dec. 13 19 79, that (I) (we) lost saw the deceased alive on Dec. 13 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE H.E. Ashworth, M.D.					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 12-14-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.E. Ashworth					22e. ADDRESS National Naval Medical Center								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/18/1979		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.					
24. FUNERAL DIRECTOR NAME Gawlers Sons Inc., Washington, D.C.					25a. DATE REC'D. BY REGISTRAR DEC 19 1979		25b. REGISTRAR'S SIGNATURE						



H.C. Culver

1/1/1914

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward J Seymour Sr			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 12 DAY 23 YEAR 1979			2b. HOUR 1:50 P.M.			
3. SEX M.	4. RACE W.	5. DATE OF BIRTH MONTH NOV DAY 15 YEAR 1916	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	7c. DATE PRONOUNCED DEAD December 23, 1979			7d. HOUR 1:30 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Clarksburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12115 Fountain Dr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGEMENT ANALYST		12b. KIND OF BUSINESS OR INDUSTRY NIH	
13a. STATE MARYLAND			13b. CITY OR TOWN MONTGOMERY		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 12115 FOUNTAIN DRIVE		
14. FATHER'S NAME FIRST JOSEPH MIDDLE SEYMOUR LAST SEYMOUR			15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE CALLAHAN LAST CALLAHAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577-03-6713		17. INFORMANT NORA J. BARDAK		ADDRESS SAME AS 13 DAUGHTER		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492- Congestive Cardiac Failure - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Cor-Pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema, Severe -									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE John S. Ball			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER		DATE SIGNED Dec. 23, 1979	
EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL			ADDRESS 7936 OLD GEORGETOWN ROAD, BETHESDA, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC 27, 1979		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.		
24. FUNERAL DIRECTOR FRANCIS J. COLLINS NAME ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION



NOV 15 1911

WASHINGTON, D. C. U.S.A.

MANAGEMENT ANALYST

RECEIVED NOV 15 1911

JOSEPH

NO 571-23-4712

200 UNIT. BLDG. W. STATION ST. WASH. D.C. 20541
FRANCIS J. COLLINS
DEC 27 1911
JOHN G. BAILL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harold SHAPIRO			2a. DATE OF DEATH MONTH DAY YEAR December 27 1979			2b. HOUR 1230P M				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 2 1922		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Air Force		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 716 Downs Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Sam Shaprio			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Witchell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 082 14 4213		17. INFORMANT Hannah Shapiro		ADDRESS See item 13				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Renal cell carcinoma with metatasis to liver 1890 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Dec. 24, 1979, to Dec. 27, 1979, that (I) (we) lost saw the deceased alive on Dec. 27, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Mark D. Browning			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED Dec. 27 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark D. Browning, M.D.			22e. ADDRESS National Naval Medical Center, Bethesda, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Memorial Chapel			ADDRESS Rockville /Md.			DATE REC'D. BY REGISTRAR JAN 2 1980		25. REGISTRAR'S SIGNATURE		

RECEIVED
JAN 10 1964
U.S. AIR FORCE



Deceased by Michael G. Gammery
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 1 4 1 1 REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR a	
Russell L. Shiflett								December 15, 1979		11:45 M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		Caucasian		May 6, 1911		68 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Montgomery County MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hospital				Engineer		U.S. Gov't.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Maryland		Montgomery		Bethesda				7113 Clarendon Road			
14 FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
John Shiflett						Molly Joseph					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS					
yes				WW II		579-03-4706 Lenore Shiflett, Same as #13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Prostate</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
				P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15/79</u> to <u>12/15/79</u> that (we) last saw the deceased alive on <u>12/15/79</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.											
22b. SIGNATURE <u>Robert C. Macon</u> DEGREE <u>M.D.</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Robert C. Macon, M.D.						809 Viers Mill Rd. Rockville, MD					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				12/18/79		Parklawn Mem. Park		Rockville, Maryland			
24 FUNERAL DIRECTOR NAME						24b. ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland								DEC 20 1979			

10

DEC 20 1978

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. IF THE MEDICAL EXAMINER IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE EXECUTED BY THE REGISTRAR. IF THE REGISTRAR IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE EXECUTED BY THE CHIEF MEDICAL EXAMINER. IF THE CHIEF MEDICAL EXAMINER IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE EXECUTED BY THE FUNERAL DIRECTOR. IF THE FUNERAL DIRECTOR IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE EXECUTED BY THE DIVISION OF VITAL RECORDS. IF THE DIVISION OF VITAL RECORDS IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE EXECUTED BY THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE. IF THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE IS NOT AVAILABLE, THE CERTIFICATE SHOULD BE EXECUTED BY THE BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31412	
1. DECEASED NAME (TYPE OR PRINT) Michael B Showalter										2b. DATE KNOWN OF DEATH 12 28 1979	
3. SEX M 4. RACE W 5. DATE OF BIRTH MAY 17, 1900 6. AGE (IN YEARS) 79 YRS. 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN 8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN										2c. DATE PRONOUNCED DEAD Dec 28 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban HOSPITAL										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAINTING CONTRACTOR	
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN ROCKVILLE 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 420 READING AVENUE											
14. FATHER'S NAME GEORGE SHOWALTER 15. MOTHER'S MAIDEN NAME ELIZABETH ELLEN BLOSSER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 578-18-7274 17. INFORMANT SON ADDRESS 703 DRYDEN STREET SILVER SPRING, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia bilateral DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Cathexia DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Trauma from Auto Accident										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute 6 months 7 month	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Cardio Vascular Disease - Carcinoma of Prostate & bone Metastasis											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 10:30 PM 4-26 1979 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 2 car accident											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street 21f. LOCATION 13409 Notley Rd. Silver Spring Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John G. Ball TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED Dec 29, 1979											
EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL ADDRESS BETHESDA, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE JAN 1, 1980 23c. NAME OF CEMETERY OR CREMATORY TRISSEL CHURCH CEMETERY 23d. LOCATION (CITY OR TOWN, COUNTY, STATE) BROADWAY VIRGINIA											
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 25a. DATE REC'D. BY REGISTRAR JAN 2 1980 25b. REGISTRAR'S SIGNATURE Robert McBrady											



MAY 17 1960

U.S.A.

VIETNAM

WITTING CONTRACTOR

HOSPITAL

AND READING AVENUE

BOCA RATON

WESTON

WALTON

STREET

SHAWNEE

ELIZABETH

ELLEN

CLARK

275-18-1000

MICHAEL T. SHAWNEE

275-18-1000

WESTON, WISCONSIN

JOHN G. BALL

WESTON, WISCONSIN

JAN 1 1960

WESTON

275-18-1000

WESTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 4 1 3 REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD E. SHRYOCK			2a. DATE OF DEATH MONTH DAY YEAR 12 23 79			2b. HOUR 8:35 PM		
3 SEX Male		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 9 12 1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.			7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT. Co. MD.					
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY			12b. KIND OF BUSINESS OR INDUSTRY LAW		
13a. STATE MARYLAND		13b. COUNTY MONT.		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6213 REDWING CT.			
14 FATHER'S NAME FIRST MIDDLE LAST HENRY SOLADAY SHRYOCK				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET PAINTER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO WW 11		17 INFORMANT MARY D. SHRYOCK (WIFE) SAME AS #13		ADDRESS SAME AS #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade DUE TO, OR AS A CONSEQUENCE OF (b) Rupture Left Ventricular Wall DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Infarct, type PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): (d) Hypertensive Cardiovascular Disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 20 mins 1 hour 20 mins 5 days 20 years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-22 19 79, to 12-23 19 79, that (I) (we) last saw the deceased alive on 12-23 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert J. Tanenbery MD				DEGREE MD				22c. DATE SIGNED 12-23-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. TANENBERG				22e. ADDRESS 5711 Allentown Rd Camp Spring Md 20823							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12-26-79		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.					
24 FUNERAL DIRECTOR'S NAME JOSEPH CAWLER'S SONS, INC. 5180 WISC. AVE., N. W. WASH., D. C. 20018				25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

BP



19 31 13

[Faint, mostly illegible handwritten text, possibly a list or ledger entries.]

Robert J. Thompson
211 Avenue 70 (Cayman Islands)
1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH-16 25M
(VRA 15, 4) 1/79STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 1 4

REG. NO.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Isaac N/A Shuster			2a DATE OF DEATH MONTH DAY YEAR 12 15 79		2b HOUR 9:55 PM
3 SEX m	4 RACE W	5 DATE OF BIRTH MONTH DAY YEAR Sept. 29, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Merchant	12b KIND OF BUSINESS OR INDUSTRY Grocery
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 12000 Old Georgetown Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Isaac --- Shuster			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hinde --- (Unknown)		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A 578-20-2044A		17 INFORMANT ADDRESS Hollywood, Fla. Dr. Marvin Shuster, 936 S. Lake Dr., Fla.	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 5715 HEPATIC FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14R.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b). DUE TO, OR AS A CONSEQUENCE OF POST-NECROTIC CIRRHOSIS	UNKNOWN
	(c). DUE TO, OR AS A CONSEQUENCE OF	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (i) (this hospital) attended the deceased from 12/15 19 79 to 12/15 19 79, that (ii) (we) lost saw the deceased alive on 12/15 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did (did not) view the body after death.					
22b SIGNATURE Roger Stevenson Jr MD		DEGREE		22c DATE SIGNED 12/15/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ROGER STEVENSON, JR MD		22e ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 12/17/79	23c NAME OF CEMETERY OR CREMATORY Beth Shalom Cem.	23d LOCATION CITY OR TOWN COUNTY STATE Capitol Hts. D. Geo. Md.
24 FUNERAL DIRECTOR NAME Banzansky-Goldberg Mem. Chap. Rockville, Md.		25a DATE REC'D. BY REGISTRAR DEC 19 1979	



DEC 9 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 4 1 5	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) LENA SILVERSTONE					2a DATE OF DEATH MONTH DAY YEAR 12/12/79			2b HOUR 1 A M			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 05 18 1900		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		8b CITIZEN OF WHAT COUNTRY? U.S.A.		9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH BETHESDA MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b KIND OF BUSINESS OR INDUSTRY DEPT. STORE			
13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN CHEVY CHASE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 8600 SPRINGDELL PLACE			
14. FATHER'S NAME FIRST MIDDLE LAST IRVING BISHOP				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUHEL GOLDMAN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 577-03-3727		17 INFORMANT ADDRESS MRS. ROSALIE LERNER, same as # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4370 } DUE TO, OR AS A CONSEQUENCE OF (b) Necrotic Decubitus Ulcer with erosion into rectum (c) Arteriosclerotic Cerebrovascular Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days ? days ? years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes Mellitus, Inanition											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 12/11, 1979, to 12/14, 1979, that (I) (we) lost saw the deceased alive on 12/11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Michael Emmer M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 12/12/79.			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael Emmer MD				22e ADDRESS 10401 OLD GEORGETOWN RD BETHESDA							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 12/13/1979		23c NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE ADELPHI PRINCE GEORGES MD.					
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.				25 DATE REC'D. BY REGISTRAR DEC 17 1979		25 REGISTRAR'S SIGNATURE [Signature]					

LEA SILVERSTONE

FEMALE

WHITE

02 18 1900

79

M. TERRY

W. A. A.

W. A. A.

BETHESDA, MD.

SUBURBAN HOSPITAL

MERCHANT

WEST ST.

W. A. A.

W. A. A.

W. A. A.

W. A. A.

W. A. A.

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W. A. A.

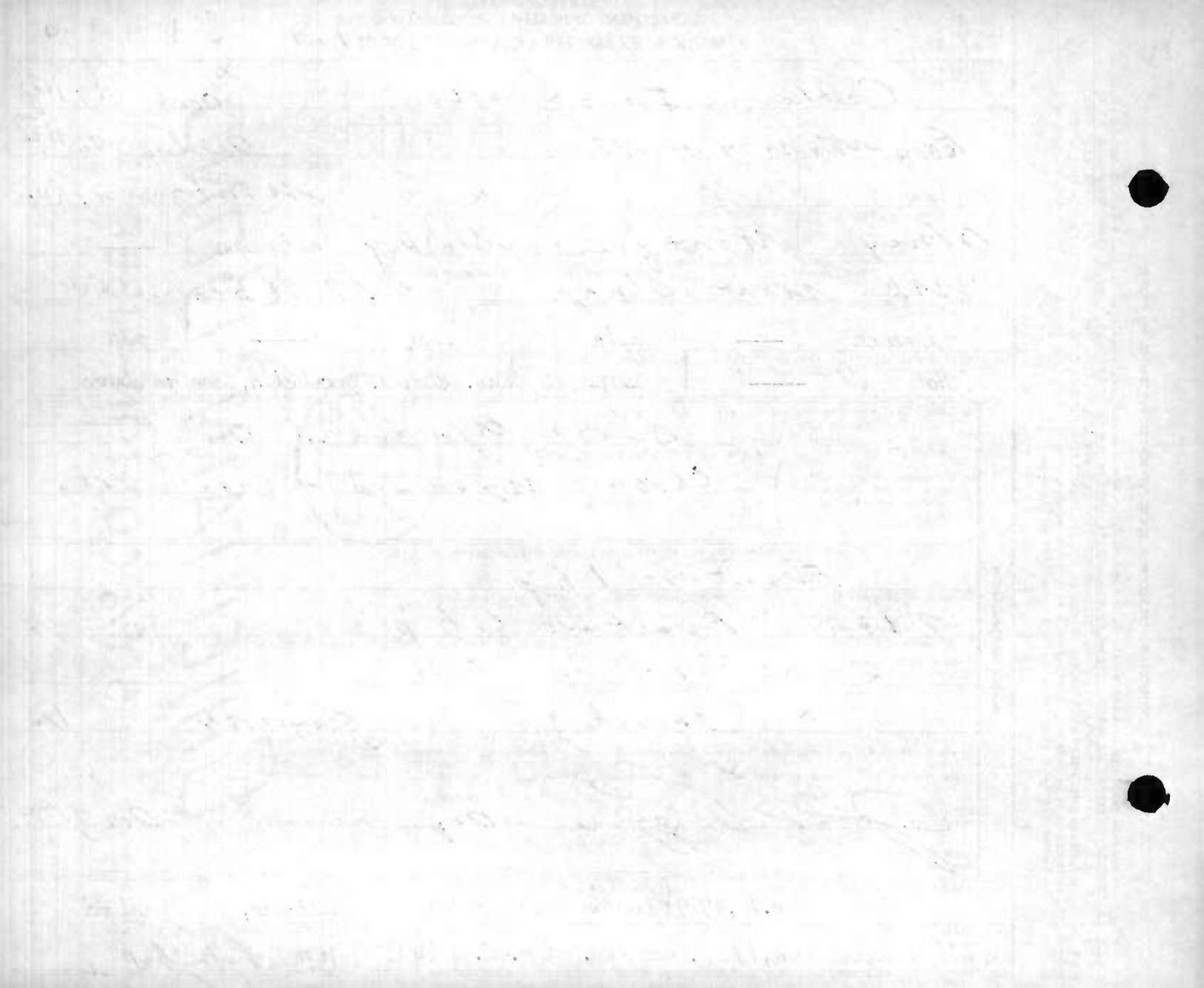
W. A. A.

W. A. A.

W. A. A.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										7 9 3 1 4 1 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Catherine Irene Skelton</i>										2a. DATE KNOWN OF DEATH <i>Dec 6, 1979</i>										11. HOUR <i>11:30 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 24 1942</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>37</i> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <i>Dec 6, 1979</i>										11. HOUR <i>11:30 PM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery Co. MD.</i>											
10. CITY OR TOWN OF DEATH <i>Olney</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Montgomery General Hosp., Saleperson</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>-----</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>							
13a. STATE <i>MD</i>				13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Olney</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>17036 Georgia Ave.</i>													
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clarence ----- Kyle</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary ----- Handy</i>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>220-03-4214</i>				17. INFORMANT ADDRESS <i>Mrs. Helen J. Boccabella, Same as above</i>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4291</i> IMMEDIATE CAUSE (a) <i>Sudden Myocardial Infarct</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Myocardial Infarct</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-----</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Yrs</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Fracture L hip</i>																							
19a. DATE OF OPERATION <i>7-28-79</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fracture L hip</i>										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR <i>P.M. 7-11 1979</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fall</i>															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Gloucester Md</i>															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>[Signature]</i>				TITLE (SPECIFY) M.D. <i>Dep.</i>				MEDICAL EXAMINER				DATE SIGNED <i>Dec 7 1979</i>											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Dec. 10, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>													
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCully Funeral Home, 130 E. Font Ave. Balto. Md.</i>										25a. DATE REC'D. BY REGISTRAR <i>DEC 11 1979</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6001

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR		7 9 3 1 4 1 7		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Isadore				Skolnick						12		24		79		3:58		P	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
male		white		9-26-1899		80		YRS		MONTHS		DAYS		HOURS		MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH													
Russia		USA				Montgomery County		MD											
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Bethesda		Suburban Hospital		Retailer		Formal Wear													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7420 Westlake Terrace											
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST									
Mayer		Skolnick				Esther				(unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS													
No		577-03-2170		Leonard Maites; 11401 Toulone Dr., Potomac, Md															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
2500		Coronary Artery Disease		Coronary Artery Disease		Diabetes, Hypertension													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		Peripheral Vascular Disease																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED											
		Charles B. Abrams						R/24/79											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
CHARLES B. ABRAMS, M.D.		2141 R St. Wash D.C.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Burial		12-26-79		Beth Shalom Cem.		Capitol Heights, Maryland													
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Danzansky-Goldberg Chapels; 1170 Rockville Pike		Rockville, Md.		JAN 2 1980															

11 21 11

St. John's

Islands

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1880

1880

Montgomery County

Suburban Hospital

Bethesda

1880

1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 4 1 8			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY LANCASTER SLYE, JR				2a DATE OF DEATH MONTH DAY YEAR 12 13 79		2b HOUR MIN 6 AM	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JULY 30, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED MANAGER		12b KIND OF BUSINESS OR INDUSTRY BAKERY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY MONTGOMERY 13c CITY OR TOWN SILVER SPRING				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 1601 COTY DRIVE	
14 FATHER'S NAME FIRST MIDDLE LAST HARRY LANCASTER SLYE				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE T. GREEN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 578-09-6691		17 INFORMANT ADDRESS (SAME AS #13 ABOVE) MRS. JANET SLYE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>220 Unstable Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1579</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mts	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a DATE OF OPERATION 2 months ago		19b CONDITION FOR WHICH OPERATION WAS PERFORMED C.A. Paresano		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Garage		21f LOCATION (STREET) CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>12/13/79</u> to <u>12/13/79</u> , that (I) (we) last saw the deceased alive on <u>12/13/79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.							
22b SIGNATURE H. L. MARTER				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 12-13-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) H. L. MARTER				22e ADDRESS 731 University Blvd E			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 12/17/79		23c NAME OF CEMETERY OR CREMATORY ROCK CREEK		23d LOCATION (CITY OR TOWN) COUNTY STATE WASHINGTON, D.C.	
24 FUNERAL DIRECTOR'S NAME TAKOMA FUNERAL HOME, INC.		ADDRESS 254 CARROLL ST. N.W. WASH. D.C.		25a DATE REC'D. BY REGISTRAR DEC 17 1979		25b REGISTRAR'S SIGNATURE R. J. Kelly	

7/11

Montgomery 11-24
1910

Montgomery 11-24
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Montgomery 11-24
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 7 9 3 1 4 1 9							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Loretta Grace Smallwood						2a. DATE OF DEATH MONTH DAY YEAR 12/1/79		2b. HOUR 8:15 A M	
3. SEX F.		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6-29-12		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired.		12b. KIND OF BUSINESS OR INDUSTRY GSA	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Mont. 13c. CITY OR TOWN Takoma Park						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7525 Carroll Ave. (Sligo Gardens Nursing home)	
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel M M Bell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret M M Shay					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-34-7633		17. INFORMANT Chart. at Hospital			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1830 Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) adenocarcinoma ovary DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bilateral gangrene feet; diabetes mellitus									
19a. DATE OF OPERATION Oct 5, 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bilat. amputation-gangrene				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 13, 1979, to Dec 1, 1979, that (I) (we) last saw the deceased alive on Nov 29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hubert J. Alpert, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec. 1, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT, M.D.				22e. ADDRESS 8630 FENTON ST. SILVER SPRING, MD. 20910					
23a. BURIAL (CREMATION) REMOVAL (SPECIFY) Cremation		23b. DATE 12/2/1979		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D C			
24. FUNERAL DIRECTOR NAME Halden United - Demaïne Funeral Home, Alexandria, Va 22314				25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 2 0

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Dorothy Ethel SMITH		2a. DATE OF DEATH MONTH DAY YEAR December 16 1979	
3 SEX Female		2b. HOUR 1220P M	
4 RACE Caucasian		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
5 DATE OF BIRTH MONTH DAY YEAR Sept. 7 1919		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. CITY OR TOWN Annapolis	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1924 Old Annapolis Blvd.	
14. FATHER'S NAME FIRST MIDDLE LAST Edward J. Hines Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie K. Krebs	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 218/05/2532	
17. INFORMANT ADDRESS LTC Marlin Smith, Sr. USAF Ret. See item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1539 METASTATIC COLON CARCINOMA TO LIVER</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 12</u> , 19 <u>79</u> , to <u>Dec. 16</u> , 19 <u>79</u> , that (I)/(we) lost saw the deceased alive on <u>Dec. 16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I)/(we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Michael Vincent</u>		22c. DATE SIGNED Dec. 17, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Vincent</u>		22e. ADDRESS National Naval Medical Center, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 20, 1979	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.	
24. FUNERAL DIRECTOR NAME <u>Singleton Funeral Home</u>		25a. DATE REC'D. BY REGISTRAR DEC 18 1979	
25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

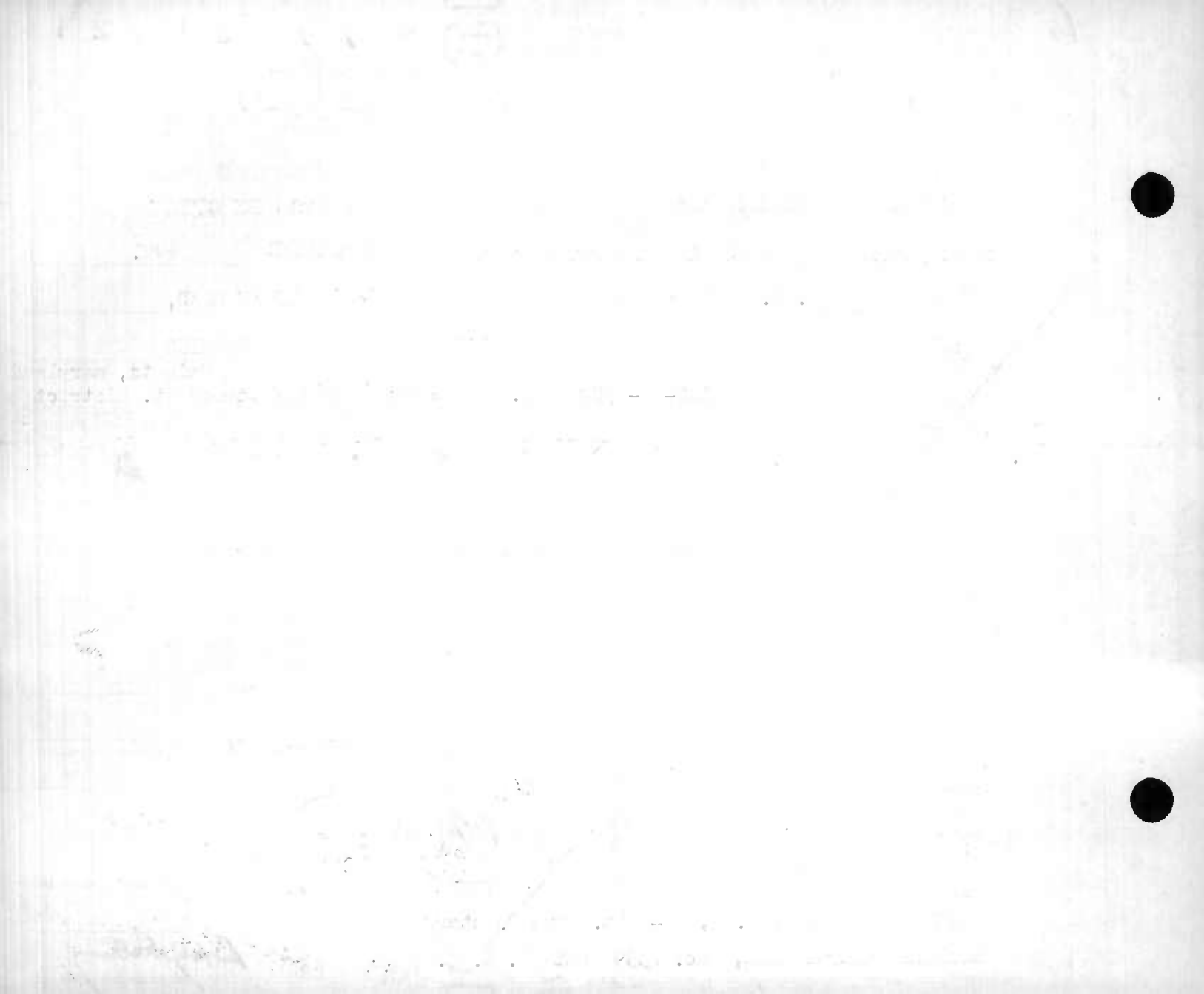
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 4 2 1	
1- FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) Firmon Louis Smith					2a DATE OF DEATH MONTH DAY YEAR 12 128 179			2b HOUR 3³⁵ P.M.			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 1 5 13		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS 66			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b KIND OF BUSINESS OR INDUSTRY PVT.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY P. G. 13c CITY OR TOWN UPPER MARLBORO					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 6606 LEAPLEY ROAD,				
14 FATHER'S NAME FIRST MIDDLE LAST LOUIS SMITH			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATIE HAWKINS								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO 217-09-6578		17 INFORMANT ADDRESS Heights, Maryland MR. OMAR SMITH/SON/6805 Atwood St. District						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC EPIDERMAL CARCINOMA (L) LUNG 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (the hospital) attended the deceased from DECEMBER 1, 1979 to DECEMBER 27, 1979 , that (I) (we) last saw the deceased alive on DECEMBER 27, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b SIGNATURE James G. Brown, MD				DEGREE		22c DATE SIGNED 12/28/79					
22b PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN, MD				22b ADDRESS 6525 Belvedere Rd Baltimore, Md 20782							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE JAN. 2, 1980		23c NAME OF CEMETERY OR CREMATORY St. Luke Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Upper PG-Mrboro md					
24 FUNERAL DIRECTOR Rollins Funeral Home, Inc.				25a DATE REC'D BY REGISTRAR JAN 3 1980		25b REGISTRAR'S SIGNATURE R. J. McBratney					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		21. HOUR	
Francis Joseph Smith								12-4-799		12		4		799		37A	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		22. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	Jan 1 0574		YRS.						12-4-79		12		4		79	
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		71. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Washington, D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Takoma Park		Washington Adventist Hospital		Tax Investigator		U.S. Gov't											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		Pr. Geo.		Tak Park		YES <input type="checkbox"/> NO <input type="checkbox"/>		7213 13th Ave									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
James		Smith		Milagros		Ramizes											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS											
No		579-01-4917		Mrs. Dorothy G. Smith		-wife same as # 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>Chronic Myocardial Dis.</u> (b) <u>Chronic Myocardial Dis.</u> (c) <u>Chronic Myocardial Dis.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
4291		Yrs															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
Francis J. Collins		M.D.		Jap		Dec 4 1979											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Cremation		12/5/79		Metropolitan Crematory		Alexandria										Virginia	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Francis J. Collins		DEC 7 1979		History McCreedy													
500 University Blvd. W., Silver Spring, Md.																	



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Washington, D.C. U.S.A.

Tolson Post Tax Investigation U.S. Gov

Mr. Geo.

James

Smith

Wilkins

James

Mr. George W. Smith - with some of the

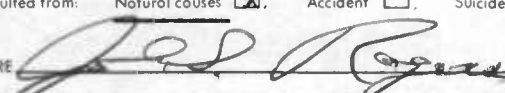
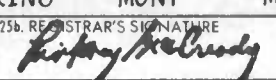
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Investigation of the
Alexander
12/7/79

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Jane B. Smith			2a. DATE OF DEATH MONTH DAY YEAR Dec 28 1979			2b. HOUR 1:55 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 29, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12017 Brook Haven Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.					13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles B. Beitzell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janie Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 05 1606		17. INFORMANT ADDRESS Kemp Smith (Husband) same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous Cell Carcinoma of</u> 179- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF <u>Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>5/1/79</u> , 19 <u>60</u> , to <u>28 Dec</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5/1/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William D. Aud MD 22c. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Aud						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/28/79		
22d. ADDRESS 9006 Colesville Rd. S.S.Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/29/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. 11800 N.H. Ave. S.S.Md.						25a. DATE REC'D. BY REGISTRAR DEC 31 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31424	
1. DECEASED NAME (TYPE OR PRINT) Katharyn Celeste Smith										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12/11 1979		2b. HOUR 3:00 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 3, 1901		6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 12/12 1979		2d. HOUR 5:23 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.						
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8718 Manchester Road, #7					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NIGHT AUDITOR		12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8718 Manchester Road, #7					
14. FATHER'S NAME FIRST MIDDLE LAST BEVERIDGE C. THOMPSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE POOLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-07-9517		17. INFORMANT DAUGHTER DOROTHY P. BROOKS,			ADDRESS 1427 CRESTRIDGE DR. SILVER SPRING, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 12/12/79					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE 							

RECEIVED
JAN 10 1964
FBI - NEW YORK
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) LAURENCE R. SMITH			2a. DATE OF DEATH MONTH DAY YEAR 12 17 79			2b. HOUR 7:45 AM				
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR AUG. 27, 1949		6 AGE (IN YEARS LAST BIRTHDAY) 30 YRS		7 IF UNDER 1 YEAR MONTHS DAYS 12 17		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ECONOMIST		12b KIND OF BUSINESS OR INDUSTRY CONSULTING CO.		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) TATE VIRGINIA					13b COUNTY UNKNOWN		13c CITY OR TOWN BURKE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST MERLIN G. SMITH					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELINORE - KLEIN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17 INFORMANT ADDRESS DOROTHY L. SMITH (WIFE) SAME AS # 13.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tt), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz)) 2050 PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) hypertension Conditions, if any, which gave rise to immediate cause (c) stroke DUE TO, OR AS A CONSEQUENCE OF (d) hypertension underlying cause lost (e) hypertension PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (f) hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2050										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (i) (his hospital) attended the deceased from 12/15/79 to 12/17/79 , that (ii) (we) lost saw the deceased alive on 12/15/79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. Dennis, M.D.				22c. DATE SIGNED 12/17/79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Dennis, M.D.		
22e. ADDRESS 831 University Blvd. Silver Spring, Md.				22f. ADDRESS 831 University Blvd. Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE DEC/18/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Riverdale, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

29

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

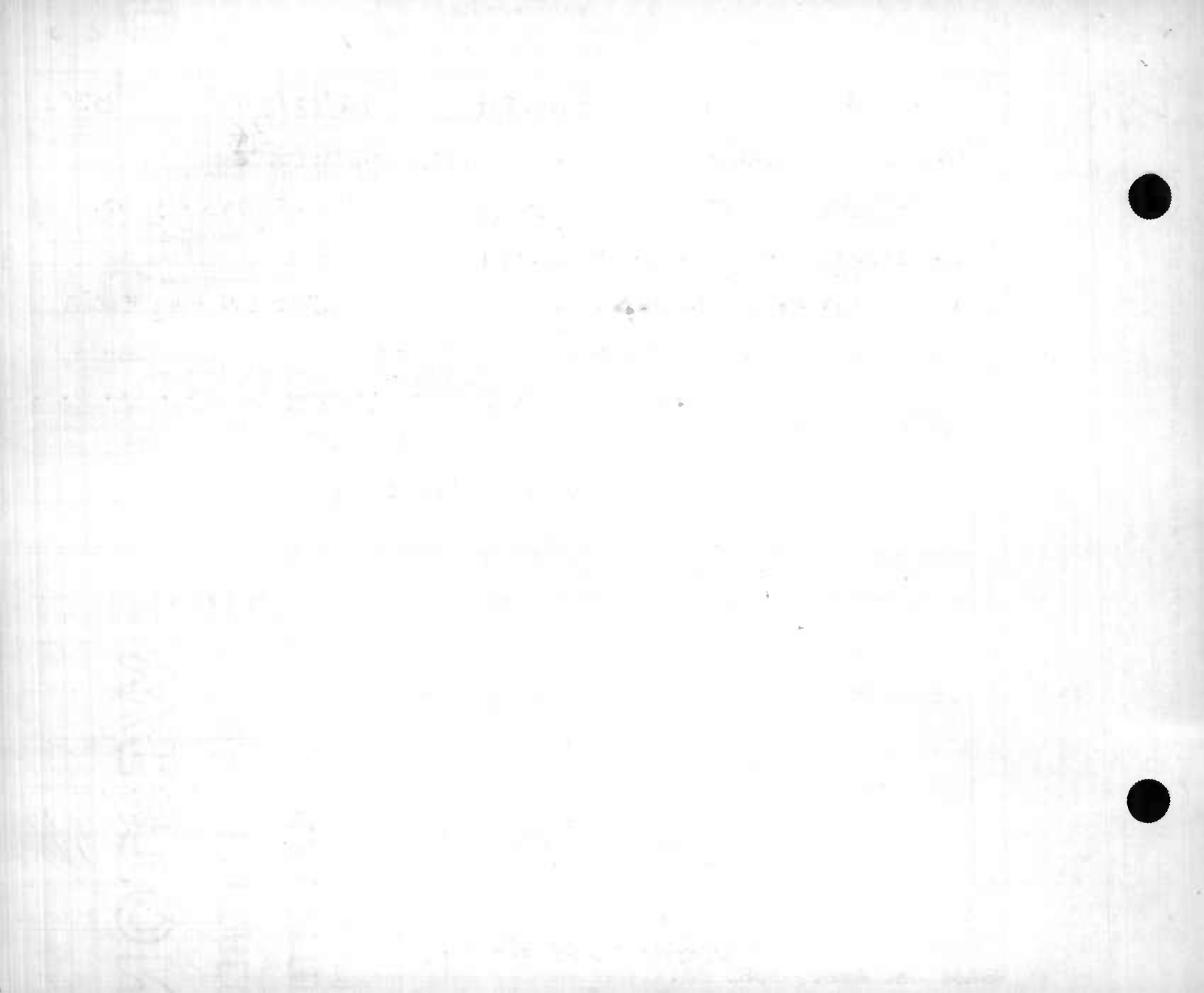
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 2 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PHYLLIS M. SMITH			2a. DATE OF DEATH MONTH DAY YEAR 12/18/79			2b. HOUR 10:30 AM								
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 2 19 1923		6. AGE (IN YEARS LAST BIRTHDAY) 56		7. IF UNDER 1 YEAR MONTHS DAYS 36		8. IF UNDER 24 HRS HOURS MIN. 36				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.								
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR Redeemer Tax Adm.		
13a. STATE MD.			13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1520 EW Hwy #252					
14. FATHER'S NAME FIRST MIDDLE LAST Edward R. McDonald			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret McNulty											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMATION Charlotte Garver-sister- 901 6th. St. S.W.DC								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) MYO CARDIOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 1977 , 19 12-18 , 19 79 , that (I) (we) last saw the deceased alive on 12-18 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.)														
22b. SIGNATURE Robert Kramer MD						DEGREE MD			22c. DATE SIGNED 12/18/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER						22e. ADDRESS 8630 FENTON RD SILVER SPRING MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-21-1979		23c. NAME OF CEMETERY OR CREMATORY Holy Name Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Ebensburg Cambria Penna.						
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.						25a. DATE REC'D. BY REGISTRAR DEC 26 1979			25b. REGISTRAR'S SIGNATURE Liaty McCreedy					
26. ADDRESS 8434 Ga. Ave., S.E. Md.														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 4 2 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Alice Pearl Soper						2a. DATE OF DEATH MONTH DAY YEAR December 26, 1979			2b. HOUR 9:30A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland						13b. CITY OR TOWN Mont.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 14315 Chesterfield Road	
14. FATHER'S NAME FIRST MIDDLE LAST Laban B. Armstrong						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie - Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-03-0474		17. INFORMANT ADDRESS Dorothy S. Bready Same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 586- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure / pneumonia / CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/26 12/24											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Acute myeloid leukemia - early myelogenous leukemia</u>											
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>				19c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>No injury</u>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>79</u> , to <u>12/26</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/30</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. Schoengold MD</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/26/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur Schoengold, M. D.						22e. ADDRESS 1811 Prince Philip Dr. Olney, MD 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1979		23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION Laytonsville Mont. Md.					
24. FUNERAL DIRECTOR NAME Francis H. Barber						25. DATE REGD. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP



and Lafayetteville

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Lois F. SPICER										2a. DATE OF DEATH MONTH December DAY 27 YEAR 1979		2b. HOUR 7:55P M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH August DAY 21 YEAR 1949		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Ft. Meade		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3535-B McWhorter Court					
14. FATHER'S NAME FIRST Gilbert MIDDLE O. LAST Pierce					15. MOTHER'S MAIDEN NAME FIRST Maybelle MIDDLE M. LAST Boettcher								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 476 60 4043		17. INFORMANT ADDRESS John A. Spicer See item 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia													
2050 DUE TO, OR AS A CONSEQUENCE OF (b) 													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from February 19 78 , to December 27 19 79 , that (I) (we) lost saw the deceased alive on December 27 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Marina Nikki Vernales						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED Dec. 28 1979				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marina Nikki Vernales, M.D.						22e. ADDRESS National Naval Medical Center, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Warba Cemetery		23d. LOCATION CITY OR TOWN Warba COUNTY Itasco STATE Minnesota					
24. FUNERAL DIRECTOR NAME Capitol Funeral Service ADDRESS Fairfax, Va.						25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE Anthony McHenry					

U. S. A. E. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 7 9 3 1 4 2 9							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert Louis Stea						2a. DATE OF DEATH MONTH DAY YEAR 22 December 1979		2b. HOUR 12:50 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) service Manager		12b. KIND OF BUSINESS OR INDUSTRY Auto	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11109 Troy Road 20852	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Stea				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Sylvester					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean 578-42-9818		17. INFORMANT ADDRESS Lola Kullback (Mother) 2423 Homestead, Dr Silver Spring, md					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration DUE TO, OR AS A CONSEQUENCE OF (b) Glioblastoma multiforme DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death 8 hours 1 Year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 21, 1979 to December 22, 1979 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 22, 1979 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) (saw) the body after death.									
22a. SIGNATURE DEGREE William L. Lanzer MD						22c. DATE SIGNED 12-22-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William L. LANZER						22e. ADDRESS National Institutes of Health, Clinical Center, Bethesda, MD 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-26-79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Pr. Geo., Maryland			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home, Inc.						25. DATE RECEIVED BY REGISTRAR (BY REGISTRAR'S SIGNATURE) DEC 28 1979			
11800 New Hampshire Ave., Silver Spring, Md.									

BP



PROOF





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH-17
(VR A15 ME (5))
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										79		31430	
FOR REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERA STERLING										2a. DATE KNOWN OF DEATH MONTH DAY YEAR Dec 24 1979		2b. HOUR OF ESTIMATED MATED 2:40 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 27, 1894		6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.		7. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Dec 24 1979		2d. HOUR 2:53 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Srl Spg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15310 Beaverbrook Ct				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
13a. STATE MD				13b. COUNTY Montgomery				13c. CITY OR TOWN Srl Spg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15310 Beaverbrook Ct	
14. FATHER'S NAME FIRST MIDDLE LAST WOLF STERLING				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY COHEN				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. 577-62-1910				17. INFORMANT EDITH S. GLICKFIELD ADDRESS 15310 BEAVERBROOK CRT., SILVER SPRING, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Cardio-Pulmonary Dis. yrs. DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION FIRST STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE JOHN S. ROGERS, M. D.				TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER				DATE SIGNED Dec 24 1979					
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M. D.				ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 12/27/1979		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PR. GEORGES MD.			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.										25a. DATE RECEIVED BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

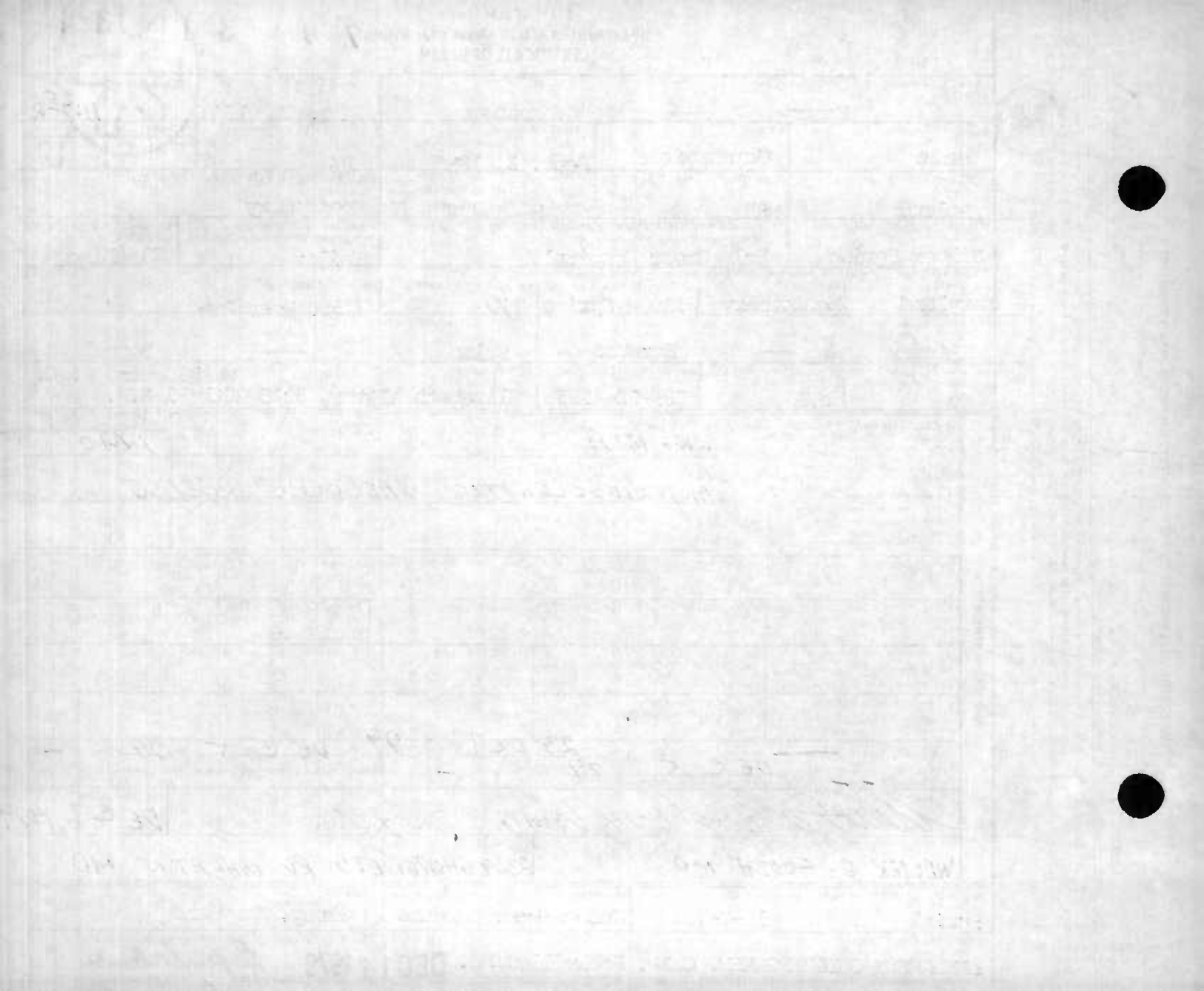
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry --- Strauss			2a. DATE OF DEATH MONTH DAY YEAR Dec. 5, 1979		2b. HOUR 11:25 P.M.					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tailor		12b. KIND OF BUSINESS OR INDUSTRY Clothing			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2550 Ross Road	
14. FATHER'S NAME FIRST MIDDLE LAST Eliazer --- Strauss			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen --- Boozel			16. ADDRESS Washington, D. C.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Elizabeth Alster, 6315 28th Pl N.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) UREMIA DUE TO, OR AS A CONSEQUENCE OF b. ARTERIOSCLEROTIC VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MO		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (myself) attended the deceased from 23 OCT 19 79 , to DEC 5 19 79 , that (I) (we) lost saw the deceased alive on DEC 5 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										
22b. SIGNATURE Walter E. Goldberg DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED DEC 6, 1979				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD					22e. ADDRESS 2309 SHOREFIELD RD WHEATON, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-7-79		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.						25a. DATE REC'D. BY REGISTRAR DEC 11 1979				
25b. REGISTRAR'S SIGNATURE Robert M. Brady										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					7 9 3 1 4 3 2	
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH			REG. NO.
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUISE IRENE STREEKS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 10 1955		2b. HOUR MIN. 5 15	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB 2, 1895	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3972 BEL PRE ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKBINDER		12b. KIND OF BUSINESS OR INDUSTRY JLUD & DETWEILL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3972 BEL PRE ROAD		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES WISE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE MAHONE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-05-7695	17. INFORMANT ADDRESS SHIRLEY K. MOYER, SAME AS 13 DAUGHTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of breast with generalized metastases 1749 DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c): APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 mos						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (i): Hypertension						
19a. DATE OF OPERATION 6/17/78		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma, right breast		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6/17 1978 to 12/8 1979 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 12/8 1979 and that in my (a) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above; (I) <input type="checkbox"/> did not view the body after death.						
22b. SIGNATURE Robert C. Haile MD		22c. DATE SIGNED 12/12/79		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT C. HAILE		22e. ADDRESS 5100 WISCONSIN AVE., WASHINGTON, D.C.				
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/13/79	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE <i>Robert C. Haile</i>		
25c. ADDRESS 500 UNIVERSITY BOULEVARD WEST, SILVER SPRING, MD						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 3 3

1. DECEASED NAME (TYPE OR PRINT) CARL ANDREW STRIDER		2a. DATE OF DEATH MONTH 12 DAY 15 YEAR 79		2b. HOUR 11:47 P.M.	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH 3 DAY 22 YEAR 57		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York, N.Y.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY retail
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD.	13b. COUNTY Montgomery	13c. CITY OR TOWN Sliver Sg.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 603 Sligo Ave	
14. FATHER'S NAME FIRST Carl MIDDLE A LAST Strider		15. MOTHER'S MAIDEN NAME FIRST Phillis MIDDLE Webb LAST Webb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 114-50-5567		17. INFORMANT Ferlister Webb ADDRESS so. ozone Pk. N.	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Delirium Tremens 2910 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Alcohol Abuse DUE TO, OR AS A CONSEQUENCE OF (c) Alcohol Abuse DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Alcoholic Hepatitis Alcoholic Pancreatitis					
19a. DATE OF OPERATION 12-15-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Alcoholic Pancreatitis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-6-79 to 12-15-79 , that (I) (we) lost saw the deceased alive on 12-15-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Steven A. Burger MD		DEGREE MD		22c. DATE SIGNED 12-16-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven A. Burger		22e. ADDRESS 10301 Georgia Ave. Silver Spring, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/21/79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland		24. FUNERAL DIRECTOR NAME R.N. Horton Co. Morticians 600-Kennedy Street			
25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

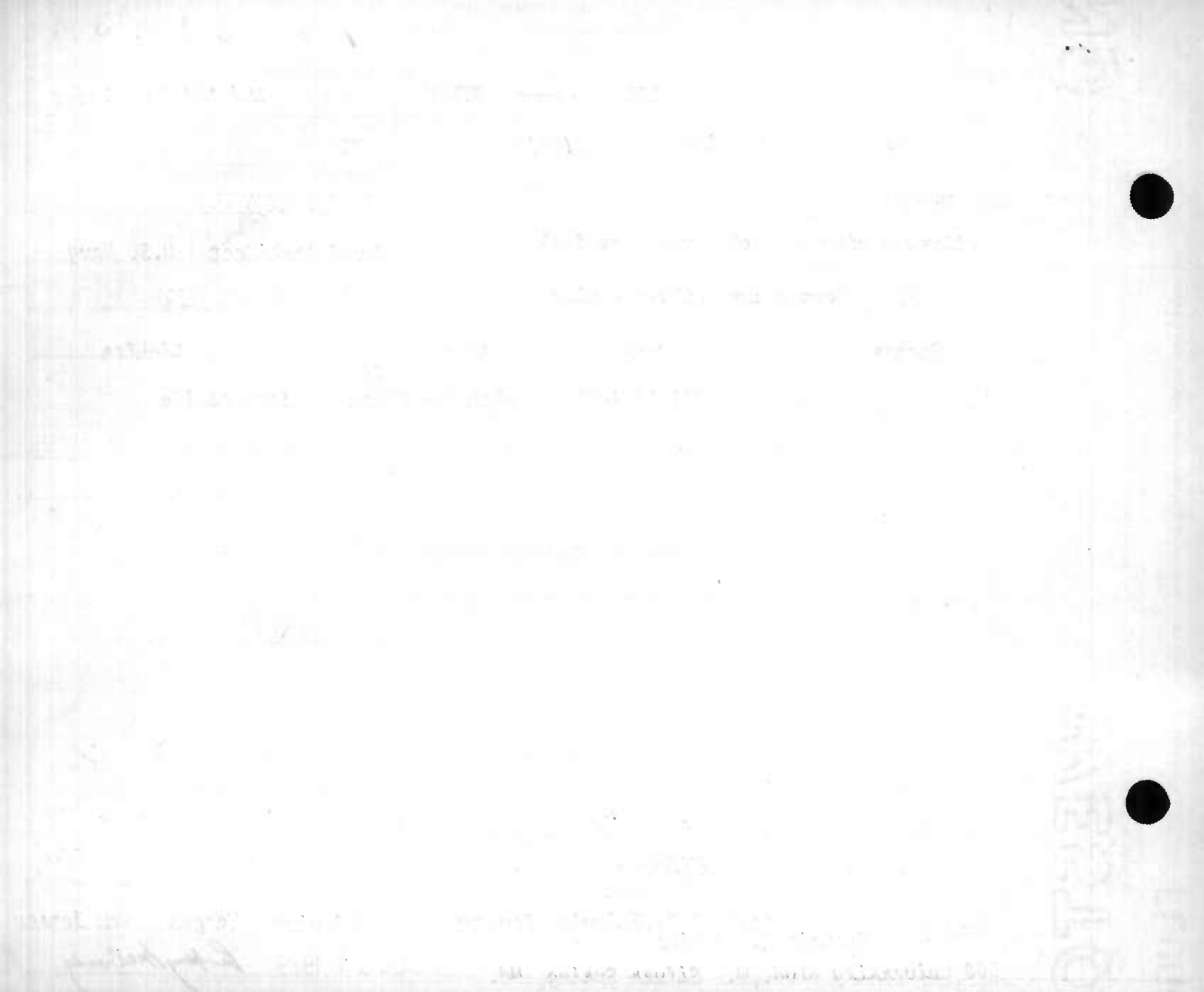
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 3 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE WILLIAM STURM STURM		2a. DATE OF DEATH MONTH DAY YEAR 12/ 16/ 79		2b. HOUR 1:54p M	
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 5/05/09 ^{AY}		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Naval Architect		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy			
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST George		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Eichler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 151-10-4433		17. INFORMANT wife Mabel S. Sturm ADDRESS Same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac dysrhythmia</u> 4/10 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction, probable</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs " years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> , 19 <u>79</u> , to <u>12/16</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>George S. Kenton MD</u>		DEGREE		22c. DATE SIGNED 12/16/79	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE S. KENTON		22c. ADDRESS 10620 Georgia Ave S.E., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 20, 1979		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	
23d. LOCATION CITY OR TOWN Fairview		COUNTY Bergen		STATE New Jersey	
24. FUNERAL DIRECTOR NAME Francis J. Collins		ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR DEC 17 1979	
				25b. REGISTRAR'S SIGNATURE <u>Ruby Helms</u>	



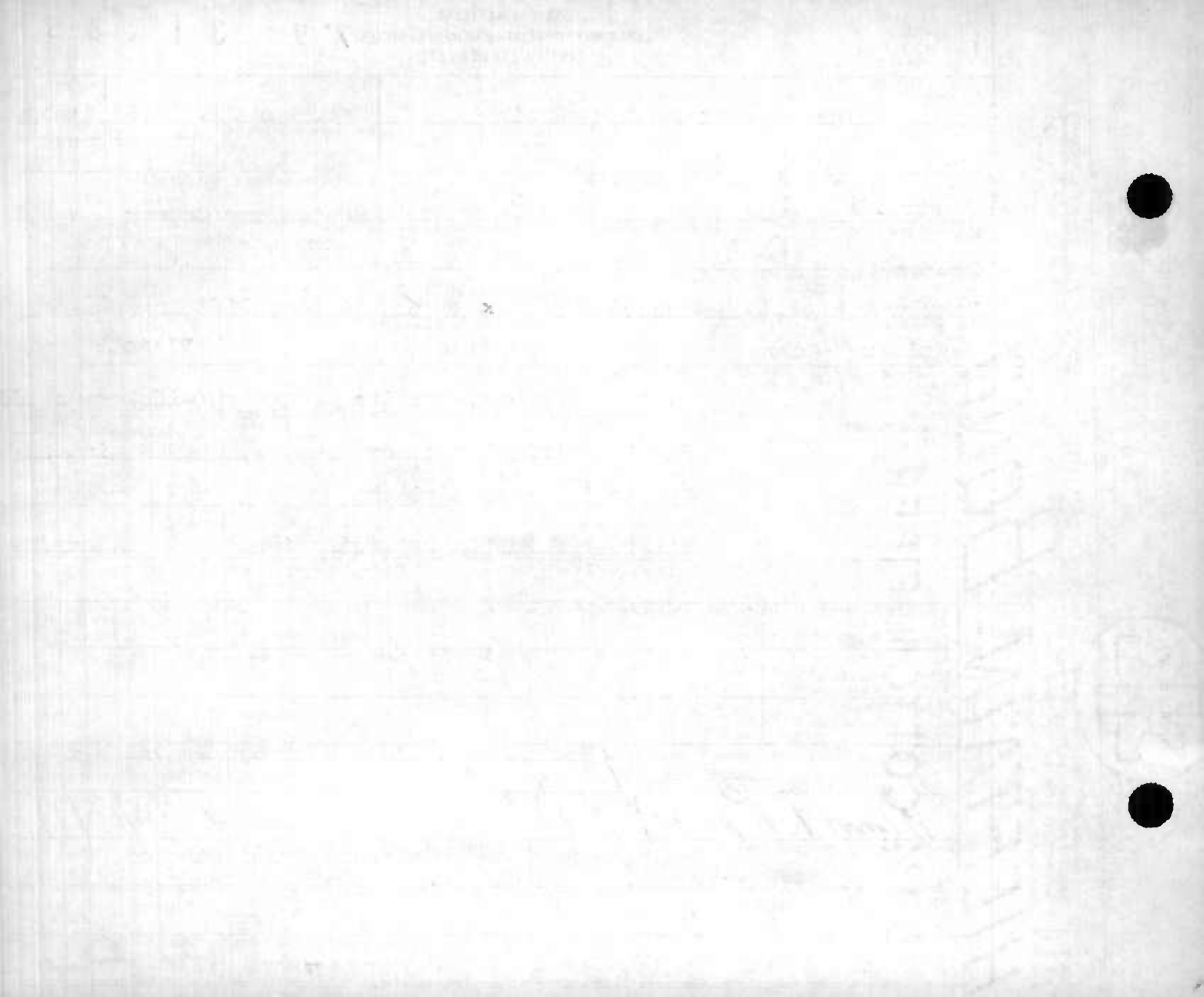
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 7 9 3 1 4 3 5							
1 DECEASED NAME (TYPE OR PRINT) Don Raymond Swain						2a. DATE OF DEATH MONTH DAY YEAR December 12, 1979		2b. HOUR 4:35pm	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 6, 1923		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7 IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Australia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b KIND OF BUSINESS OR INDUSTRY Printing	
13a STATE Maryland		13b COUNTY Balto.		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 13 Edgecliff Road 21204	
14 FATHER'S NAME FIRST MIDDLE LAST Walter John Swain				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Elliott					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 490-30-4885		17. INFORMANT ADDRESS Mrs. Juanita C. Swain (wife) same address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right ventricular hemorrhage</u> 396- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mitral and aortic regurgitation</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION December 12, 1979		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) this hospital attended the deceased from September 5, 79, to December 12, 79, that X (we) last saw the deceased alive on December 12, 79, and that in X (our) opinion death occurred on the date and hour and from the causes stated above. (U) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Glenn R. Barnhart, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12/13/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Glenn R. Barnhart, M.D.						22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/14/1979		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24 FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley Inc. Dundalk, Md.						25a. DATE REG'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE P. H. Brady	

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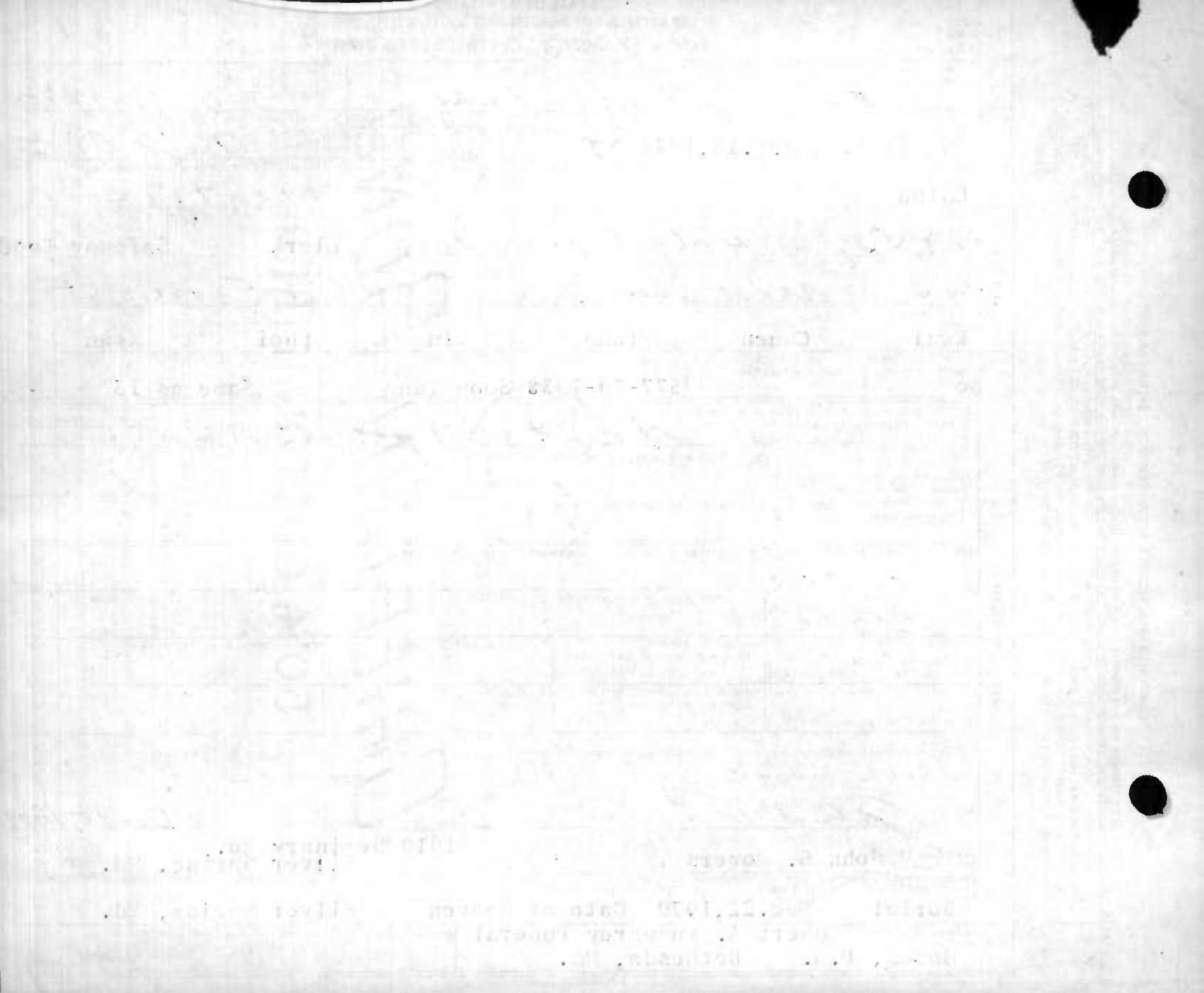
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) DAVID L. SWANSON			2a. DATE OF DEATH MONTH DAY YEAR 12 17 1979		2b. HOUR 10:50 A.M.					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Wheaton, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3811 Kayson Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY G.E. Co.		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3811 Kayson Street	
14. FATHER'S NAME FIRST MIDDLE LAST August Swanson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie J. Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 175-09-1657		17. INFORMANT daughter Reta Murray same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Electrolyte imbalance</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>kidney failure</u> 586- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 2 wks 4 wks.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension - Atherosclerosis</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/25/76</u> , 19 <u>76</u> , to <u>12/17</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/12/1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Richard P. Delaney</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12.17.79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.					22e. ADDRESS 4323 Havard Street, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 21, 1979		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Erie Erie Penn.			
24. FUNERAL DIRECTOR NAME Francis J. Collins					25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE <u>Robert Kelly</u>			
500 University Blvd., W. Silver Spring, Md.										

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 31437	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST KUI SHING TANG				2a. DATE KNOWN OF DEATH MONTH DAY YEAR Dec 18 1979	
3. SEX Male	4. RACE Oriental	5. DATE OF BIRTH MONTH DAY YEAR Aug. 10, 1944		6. AGE (IN YEARS) (LAST BIRTHDAY) 35 YRS.		7b. HOUR 10:32 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Dec 18 1979	
10. CITY OR TOWN OF DEATH Sil Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Safeway Food	
13a. STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Cherry Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Kwai Chuen Tang		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kin Choi Ngan		13e. STREET ADDRESS 2602 Farwell Ct			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-70-7938		17. INFORMANT Soon Tang		ADDRESS Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4391 IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER 1919 Seminary Rd. Silver Spring, Md.		DATE SIGNED Dec 18, 1979	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 22, 1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.	
24. FUNERAL DIRECTOR NAME Homes, P.A.		ADDRESS Bethesda, Md.		25a. DATE REC'D. BY REGISTRAR DEC 24 1979		25b. REGISTRAR'S SIGNATURE History McCreedy	



Released by Dr. Ball
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) DONALD A. THOMPSON			2a. DATE OF DEATH MONTH DAY YEAR 12 9 79			2b. HOUR 937 P M					
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR July 21, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Dakota		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elec. Engineer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11501 Piney Lodge Rd.		
14 FATHER'S NAME FIRST MIDDLE LAST Arthur Thompson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy (Unknown)			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	
17 INFORMANT Craig E. Thompson			17 ADDRESS 7127 3rd Ave. N.			17 CITY OR TOWN St. Petersburg, Fla.				17 STATE Fla.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 42554 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Primary Myocardial disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 1 year 1971 -4 years-			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from Dec 8 , 19 79 , to December , 19 79 , that (I) (we) last saw the deceased alive on Dec 8 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Luis BENTOLILA MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/9/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS BENTOLILA MD			22e. ADDRESS 5480 Wisconsin Ave Chevy Chase Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 13, 1979		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va				
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Md.						25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



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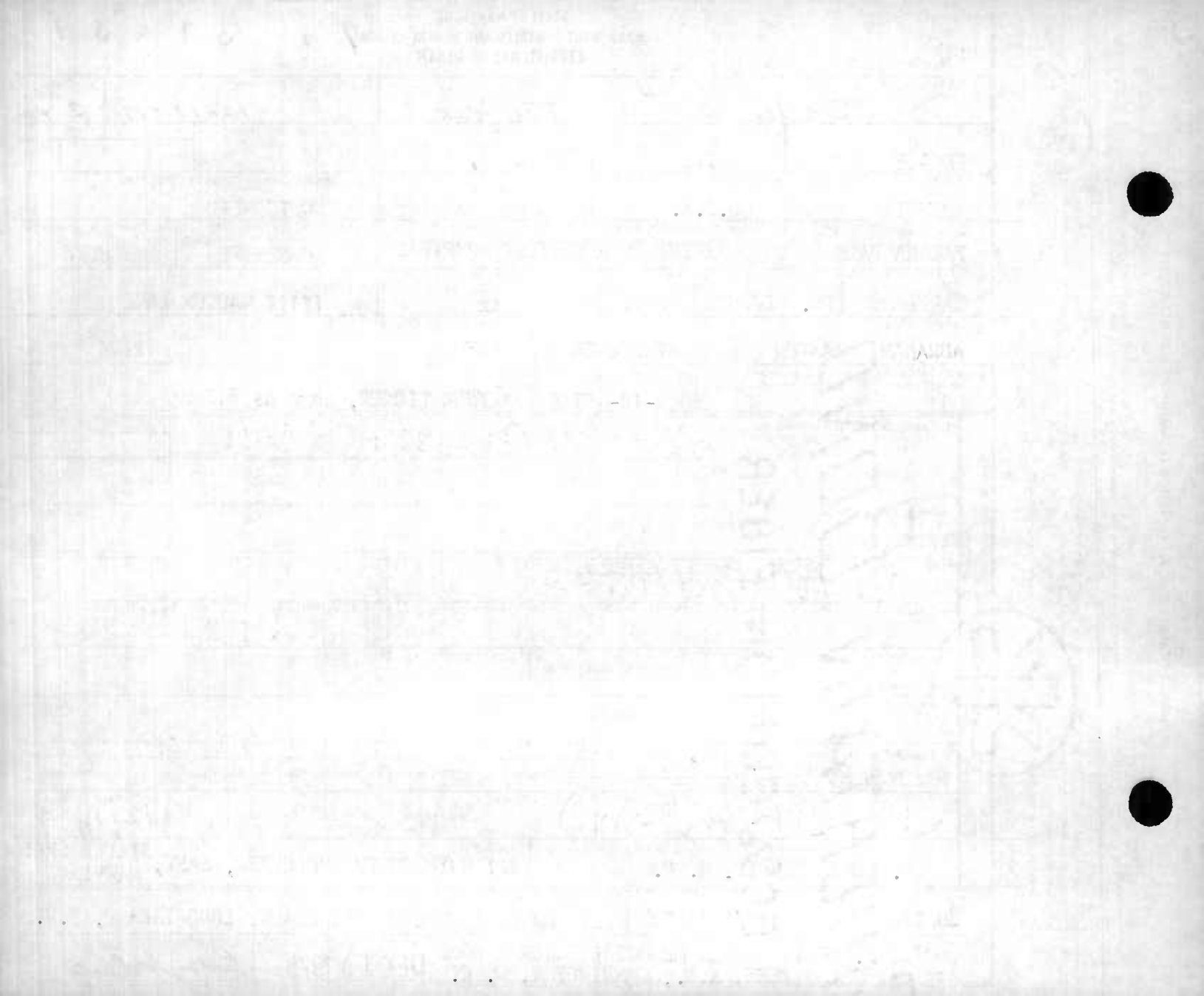
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 9 31439							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sadie N M Ticker						2a. DATE OF DEATH MONTH DAY YEAR 12-17-79		2b. HOUR 2:00 P.M.	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR APRIL 8, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND						13c. COUNTY PR. GEORGES		13d. CITY OR TOWN BOWIE	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM AARON STREICHER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER RIVA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 065-18-4394D		17 INFORMANT ADDRESS ARTHUR TICKER, same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>motor vehicle wreck</u> 179- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>disturbance mental</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> 19 <u>79</u> to <u>12/17</u> 19 <u>79</u> , that (I) (we) lost <u>above</u> the deceased alive on <u>12/24</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Lewis Dennis</u>				DEGREE		22c. DATE SIGNED 12/17/79		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LEWIS DENNIS, M. D.				22e. ADDRESS 831 UNIVERSITY BOULEVARD, EAST, SILVER SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/19/1979		23c. NAME OF CEMETERY OR CREMATORY BETH MOSES CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE PINELAWN, LONG ISLAND, N.Y.			
24 FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR DEC 19 1979		25b. REGISTRAR'S SIGNATURE <u>Robert M. B...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 79 31440							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARGARET		MIDDLE MERITHEW		LAST TITUS		2a. DATE OF DEATH MONTH DAY YEAR	
MARGARET M		TITUS						12 10 79	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		11 26 06		73 YRS.		8 30 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
New York		U.S.A.				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN Hospital				Homemaker		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input type="checkbox"/>		3112 Leland St.	
Maryland		Montgomery		Chevy Chase					
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Amera Floyd Merithew					Gertrude Thompson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		217-28-8570		George R. Titus, Husband, Same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Carcinomatosis									8 mos.
DUE TO, OR AS A CONSEQUENCE OF (b) Endometrial Carcinoma									3 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
3 yrs ago		Endometrial Carcinoma				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 1 year + 19 to 12-10 1979, that (I) saw the deceased alive on 12-10 1979, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
James W. Egan M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				12-11-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JAMES W. EGAN		5413 Cedar Ln. - Bethesda							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/ 13/1979		Monocacy Cemetery		Beallsville Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE RECORDED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.						DEC 14 1979			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 4 4 1	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		2b. HOUR	
		Gerard M. Toole						December 11, 1979		9 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS.	
Male		Caucasian		Jan. 31, 1912		67 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		6003 Maiden Lane				Salesman		Advertising			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6003 Maiden Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Robert Toole				Margaret Molloy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		064-09-0698		Gerard M. Toole, Jr.		337 Sharrots Rd. Long Island, N.Y.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Cause of the heart</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 m.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2							
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
21g. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21h. PLACE OF INJURY		STREET							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/16</u> , 19 <u>79</u> , to <u>12/12/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>James M. D Angelo, M.D.</u>								12/12/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
James M. D Angelo M.D.				5401 Western Ave. N.W. Wash. D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		Dec. 15, 1979		Gate of Heaven		Hawthorne		New York			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Robert A. Humphrey Funeral Homes, P.A. Bethesda, Md.				DEC 17 1979				<u>Robert A. Humphrey</u>			

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Robert A. Proulx, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 4 4 2	
1 - FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Grace Marie Ucciferri								12-26-79		8:50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
female		white		Nov. 1 1889		90 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Italy		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Brook Grove Foundation						housewife		own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Gaithersburg		yes		18917 Whetstone Circle			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Leonard Vallario				Anne DeMilia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (daughter) ADDRESS							
		047-44-3261		Philomena M. Campanella-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Asystole</u>										Minutes	
4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>A-S-H-D.</u>										Hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <u>Genl. Atherosclerosis</u>										Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>72</u> to <u>12-26</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-7</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE DEGREE						22c. DATE SIGNED					
Jack Schumacher M.D.						12-27-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Jack Schumacher, MD						105 Russell Ave., Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12-29-79		Gate of Heaven		Silver Spring Montgomery Md.					
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.						JAN 2 1980		[Signature]			



RECEIVED
JAN 14 1964

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Milburn Clark Vance			2a. DATE OF DEATH MONTH 12 DAY 25 YEAR 79			2b. HOUR 2:00am	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH NOV DAY 26 YEAR 1918		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADM. SUPERVISOR	
12b. KIND OF BUSINESS OR INDUSTRY VITRO LAB							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 11003 GLUECK LANE							
14. FATHER'S NAME FIRST MILLARD MIDDLE LAST VANCE				15. MOTHER'S MAIDEN NAME FIRST FERN MIDDLE LAST DILLION			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 11 515-07-7833		17. INFORMANT ADDRESS HELEN M. VANCE SAME AS 13 WIFE			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Calcification</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>11/12/79</u> to <u>12/25/79</u> , that (1) (we) last saw the deceased alive on <u>12/24/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> DEGREE				22c. DATE SIGNED <u>12/25/79</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALLAN COHEN	
22e. ADDRESS SILVER SPRING, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE 12/28/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN SILVER SPRING COUNTY MONT STATE MD	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS NAME ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD, 20901				25a. DATE REC'D. BY REGISTRAR DEC 26 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

506 LIND BLVD. N. SILVER SPRING, MD. 20901

FRANCIS J. COLLINS

12/26/79 DATE OF REVIEW

SILVER SPRING

ALLAN COHEN

SILVER SPRING, MARYLAND

ENTIREMENT

APR 28 1979

YES 1 10 11 212-67-7532 MELBA M. WANCE DATE AS 12

MILLARD

WANCE

FEIN

STILLER

MARYLAND

MONTGOMERY

KENNESAW

XX

11000 QUICK LAKE

KANSAS

U.S.A.

NOV 28 1978

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DATE

WIFE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												9 3 1 4 4 4 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST						2a. DATE KNOWN OF DEATH						2b. HOUR							
Kathleen Shirley VanEpps												2a. DATE KNOWN OF DEATH						2b. HOUR							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD						2d. HOUR							
Female		White		Jul. 4, 1902		77 YRS.						12/26 19 79						11:40 P.M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH													
Virginia				USA				WIDOWED				Montgomery County MD.													
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY													
Silver Spring				11215 Oak Leaf Drive, #1807				Post Mistress				Post Office													
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS									
Maryland				Montgomery				Silver Spring				YES				11215 Oak Leaf Drive, #1807									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																			
FIRST MIDDLE LAST						FIRST MIDDLE LAST																			
Leslie H. McCue						Margaret Shirley																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT						ADDRESS							
No						223 50 5402						John E. VanEpps (Son)						Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																									
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>																									
DUE TO, OR AS A CONSEQUENCE OF																									
(b) <u>chronic myocardial disease.</u>																									
DUE TO, OR AS A CONSEQUENCE OF																									
(c)																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																									
None																									
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?													
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
						HOUR A.M. MONTH DAY YEAR																			
						P.M. 19						None													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION													
												CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																									
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED													
<i>John S. Rogers</i>						Deputy						12/27/79													
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS																			
John S. Rogers, M.D.						1919 Seminary Road																			
						Silver Spring, Montgomery, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION													
Burial				12/29/79				Nal't Mem. Park				Falls Church Virginia													
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE													
NAME ADDRESS																									
Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.						DEC 31 1979						<i>Anthony McBrady</i>													

34

1934

CHICAGO, ILL.

DEAR MR. [Name]

I have your letter of [Date]

and am glad to hear

from you.

I am sorry that I cannot

reply more fully at present.

I am, however, very

truly yours,

[Signature]

[Name]

[Address]

[City]

[State]

[Country]

[Post Office]

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 4 5

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <i>Beatrice S. Van Bess</i>			2a. DATE OF DEATH MONTH DAY YEAR December 2, 1979			2b. HOUR 11:30 PM					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1392 Kersey Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Chester Shreve				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Martin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 054-38-7077		17. INFORMANT ADDRESS Lorraine S. Backer, Same as 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i> 4370 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) the hospital attended the deceased from <i>10/21</i> , 19 <i>76</i> , to <i>12/2</i> , 19 <i>79</i> , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on <i>11/29</i> , 19 <i>79</i> , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> I did not see the body after death.											
22b. SIGNATURE <i>Joseph J. Wallace</i> DEGREE						22c. DATE SIGNED 12/2/79			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph J. Wallace						22f. ADDRESS 5272 River Road Bethesda, Maryland 20016					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-79		23c. NAME OF CEMETERY OR CREMATORY Greenfield Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hempstead, New York			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY P. A., Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 5 1979		25b. REGISTRAR'S SIGNATURE <i>P. A. Backer</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Dear Mr. [Name]

Reference is made to your letter of [Date] regarding [Subject].

Sincerely,
[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold Robert Veit						2a. DATE OF DEATH MONTH DAY YEAR 12/16/79		2b. HOUR 5 A.M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 16 32		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 322 North West Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) State Board of Education		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 322 North West Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Harold Robert Veit		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flurence Jackson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT Betty V. Veit-Wife		ADDRESS Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Comp. & Acute Respiratory Failure 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) 1 1/2 yr. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yr.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from June 1977 to Dec. 1979 , that (I) (we) last saw the deceased alive on 12/11/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.											
22b. SIGNATURE E. S. Sejima		DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/16/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIN		22e. ADDRESS 8630 Fenton St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-17-79		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alex. Va.					
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.		24b. ADDRESS 8434 Ga. Ave. Silver Spring Md.		25a. DATE REC'D. BY REGISTRAR JAN 16 1980		25b. REGISTRAR'S SIGNATURE Harvey A. Brady					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 4 4 7 REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pennie Marie Viscardi						2a. DATE OF DEATH MONTH DAY YEAR December 14, 1979		2b. HOUR P 12:22M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 05, 1960		6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10. CITY OR TOWN OF DEATH Bethesda, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, Clinical Center, Bethesda, Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia						13b. COUNTY Fairfax		13c. CITY OR TOWN Falls Church	
14. FATHER'S NAME FIRST MIDDLE LAST Peter W Viscardi						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Brady			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 225-11-9101		17. INFORMANT (Capt USN Ret.) Mr. Peter W. Viscardi, Father (NOK)					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure, clinical</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Edema of lung, marbled</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Petechial hemorrhage of skin</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <u>xx</u> (this hospital) attended the deceased from <u>May 5, 1978</u> to <u>December 14 79</u> , that <u>xx</u> saw the deceased alive on <u>December 14 19 79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) said and set out the body after death.									
22b. SIGNATURE <u>Roger J. Porter</u> MD		DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER J PORTER MD		22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/79		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Murphy F.H. - Falls Church, Va		ADDRESS 110 W. Broad St. Falls Church, Va		25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE <u>Roy H. H. H.</u>			

RECEIVED
NOV 10 1952

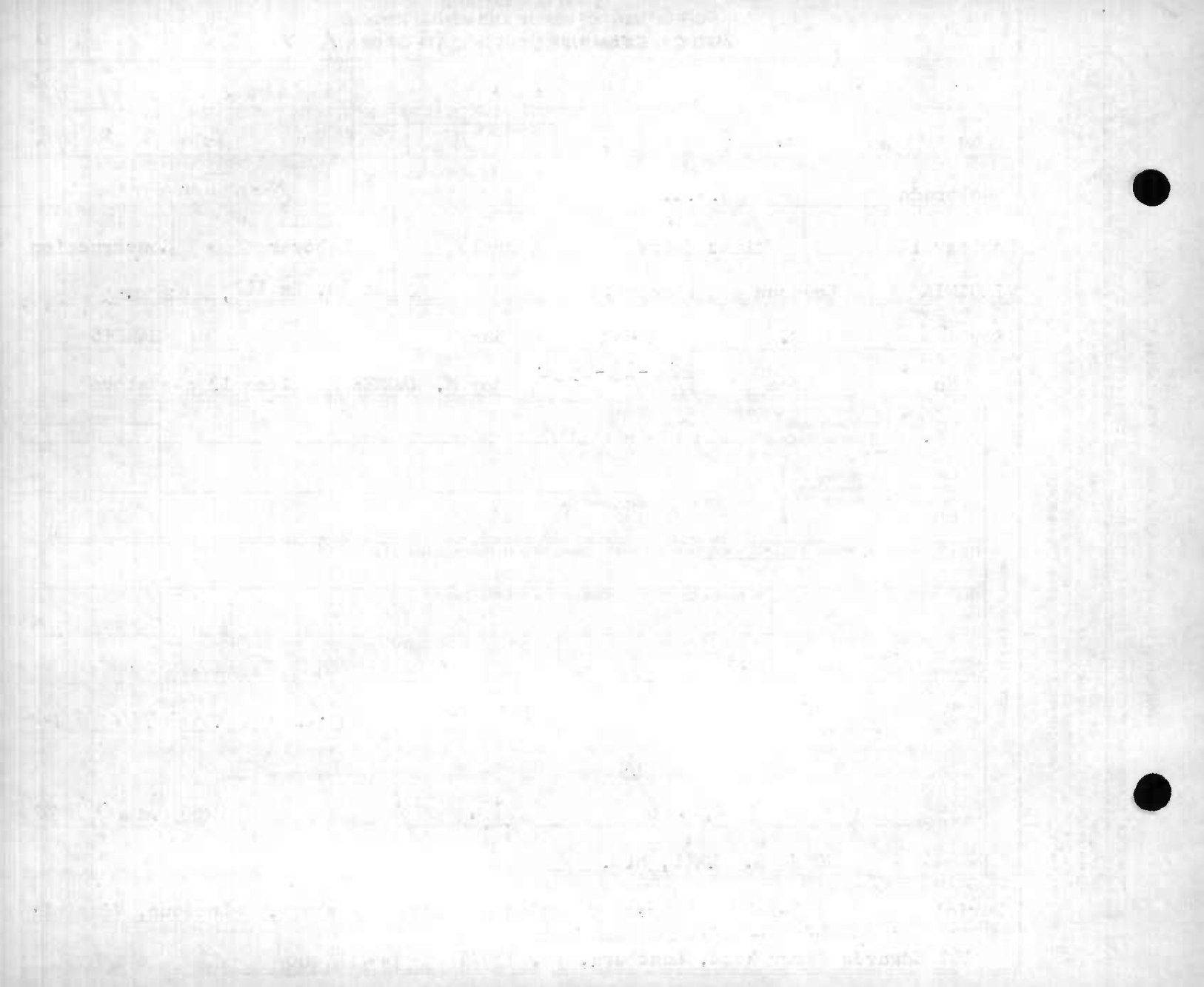


DEC 30 1952

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (1))
30M 7/73

STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31448	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard C Wagner										2b. DATE KNOWN OF DEATH ESTI. MONTH DAY YEAR 12-28-79	
3. SEX M.	4. RACE W.	5. DATE OF BIRTH MONTH DAY YEAR 4-2-61		6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan 3 1980		2d. HOUR 9:30 M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Poolesville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Whites Ferry (Rural)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE VIRGINIA		13b. COUNTY Loudoun		13c. CITY OR TOWN Lucketts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt #4, Bx 113, Leesburg			
14. FATHER'S NAME FIRST MIDDLE LAST Roy M. WAGNER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah HARRIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 226-13-6530		17. INFORMANT Roy M. WAGNER		ADDRESS Item 13 a-e above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 11:30 P.M. 12-28 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Friends to Chocant playing at water edge - fallen.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) River		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Whites Ferry Poolesville Montgomery Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy				DATE SIGNED Jan 3, 1980			
EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL, M.D.										ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-5-80		23c. NAME OF CEMETERY OR CREMATORY Leesburg Union Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Leesburg, Loudoun, Virginia			
24. FUNERAL DIRECTOR NAME MUSE-REED-RANGE FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR JAN 10 1980		25b. REGISTRAR'S SIGNATURE Lester A. Rude			
101 Edwards Ferry Road, Leesburg, VA. 22075											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 4 9

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BLAKE BLANCHE A WALKER			2a. DATE OF DEATH MONTH DAY YEAR 12 23 79			2b. HOUR 11 A M				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 1 20 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.				
10. CITY OR TOWN OF DEATH JACOB PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY D. C.		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 620 SHERIDAN ST	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY HUMPHREY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE SANFORD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 579 48 9019		17. INFORMANT ADDRESS DOROTHY JOHNSON 620 SHERIDAN ST HYATTSVILLE, MD.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Parkinsonism 3320 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH NINE		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerotic cardiovascular disease										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1972 to 12-23 19 79 , that (I) (we) last saw the deceased alive on 12-22 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Fred C Cristofari MD						DEGREE MD		22c. DATE SIGNED 12/23/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fred C Cristofari						22e. ADDRESS 3327 Superior Lane Rowley, MD 20755				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/27/79		23c. NAME OF CEMETERY OR CREMATORY HARMONY PK.		23d. LOCATION CITY OR TOWN COUNTY STATE LANDOVER, MD.			
24. FUNERAL DIRECTOR NAME ROLLINS						ADDRESS 4339 HUNT PL. NE, DC		25a. DATE REC'D. BY REGISTRAR JAN 3 1980		
						25b. REGISTRAR'S SIGNATURE Robert McCreedy				

MEDICAL CERTIFICATION

9

9

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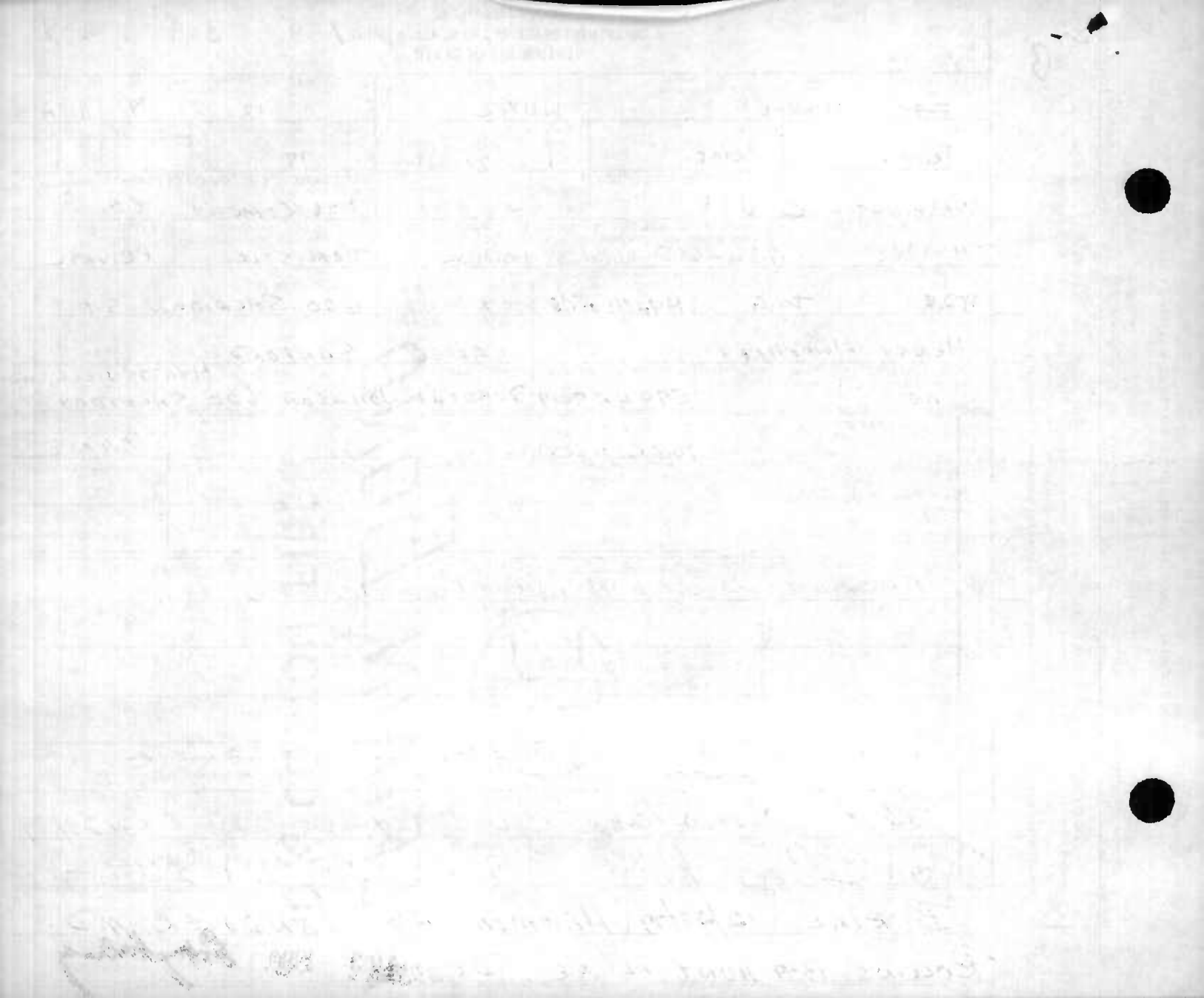
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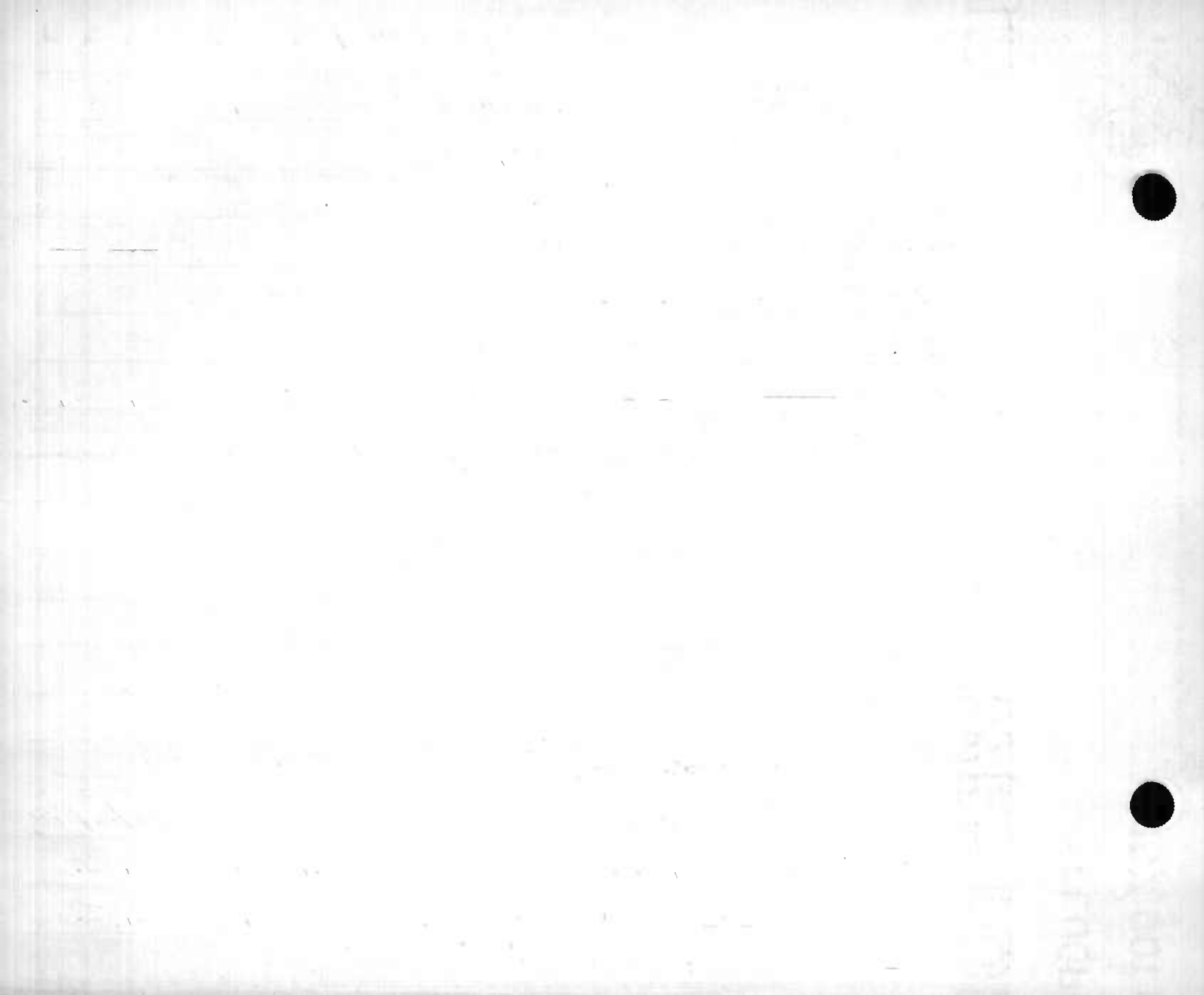
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 4 5 0	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST <u>FLORA</u>		MIDDLE		LAST <u>WALLACH</u>		2a. DATE OF DEATH MONTH DAY YEAR December 10, 1979		2b. HOUR 7:25p M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 2, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8708 1st Avenue			
14 FATHER'S NAME FIRST MIDDLE LAST Heinrich Lichtenstetter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lina Kern							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 094-20-7165		17 INFORMANT ADDRESS Susie Vollweiler; 10214 Leslie St., SSp., Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/7</u> , 19 <u>79</u> , to <u>12/10</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/10/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Herbert S. B. Baraf</u>				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HERBERT S. B. BARAF, M.D.				22e. ADDRESS 8750 Georgia Ave., Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-12-79		23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Oxon Hill, Pr. Geo., Md.					
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels;				ADDRESS 170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE <u>Notary Public</u>			



Item 1 g555 1/2/80 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
DIN-Chia		DIN		WANG	12		<input type="checkbox"/>	12	2	19 79	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
male	Oriental	Feb. 6 1949		30 YRS.					12 2 19 79		6:20 A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Taiwan		U.S.A.				Montgomery County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hospital				Accountant		Florist Shop			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Montgomery		Bethesda		YES <input type="checkbox"/> NO <input type="checkbox"/>		9314 Adelaide Dr.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST	
Hsien		Ming		Wang		Unknown		Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				579-90-8195		Shuf Wang, Wife. Same as item 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Perforating gunshot wound of head</u>											
DUE TO, OR AS A CONSEQUENCE OF (unspecified weapon)											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				5:15 PM 12-2-1979		Shot by assailant(s)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY	STATE
				house		7105 Armatt Dr., Bethesda,		Montgomery			Md.
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
				M.D. Assistant				MEDICAL EXAMINER		12-3-79	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Ann M. Dixon, M.D.				111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc. 5139 Wisconsin Ave., N.W. Washington, D.C.						DEC 12 1979					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Job. 6. 20

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M7/77

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						7 3 1 4 5 2 REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Irvin		MIDDLE B.		LAST Watkins		2a. DATE KNOWN OF DEATH ESTIMATED Dec. 13 19 79		2b. HOUR 9:40 A.M.									
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR May 6, 1912		6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Dec 13 1979		2d. HOUR 7:40 A.M.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery						MD.							
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD												13b. COUNTY Montgomery		13c. CITY OR TOWN MD Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rte 3, Long Corner Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Harry B. Watkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Estella Pickett															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-48-1796				17. INFORMANT ADDRESS Mildred V. Watkins, Item 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 4291 Acute Myocardial Dis. Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b). Chronic Myocardial Dis. (c).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None																			
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER ADDRESS Silver Spring, Md.								DATE SIGNED Dec 13, 1979							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 16, 1979		23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.				23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montg., Md.									
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.						25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE [Signature]											

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 4 5 3

1. DECEASED NAME (TYPE OR PRINT) Elsie M. Watson			7a. DATE OF DEATH MONTH DAY YEAR 12 - 24 - 79			7b. HOUR 5¹⁵ A.M.				
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 5 - 1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MINS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF FOR IN-PATIENT FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home		12a. USUAL OCCUPATION (USUAL WORK FOR MOST OF WORKING LIFE) Retired Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY Rockville				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN MD.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME (FIRST MIDDLE LAST) Edmond J. Ricketts		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Leanna Baker		16. STREET ADDRESS 6413 MacArthur Blvd.						
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-10-3996		17. INFORMANT Russell W. Gray		ADDRESS 718 Pennsylvania Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA - DUE TO, OR AS A CONSEQUENCE OF (b) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Dec. 5 , 19 77 , to December 24 , 19 79 , that (I) (we) lost saw the deceased alive on Dec 22 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M. C. Cascard MD						DEGREE MD		22c. DATE SIGNED 12/24/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MIGUEL R CASCARDO						22e. ADDRESS 12400 BOBINK CT POTOMAC Md 20854				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Dec. 28 - 1979			23c. NAME OF CEMETERY OR CREMATORY Rockville Union			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg Co. Md.	
24. FUNERAL DIRECTOR Arthur Walters			25. DATE REC'D. BY REGISTRAR DEC 28 1979			26. REGISTRAR'S SIGNATURE John J. Brady				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79	31454
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD DANA WATSON						2a. DATE OF DEATH MONTH DAY YEAR 12-4-79		2b. HOUR 12:50AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11-8-1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. HAMPSHIRE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OR SPECIES OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY VITRO			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING			
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT M. MARTIN WATSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA HOBBY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-03-5419		17. INFORMANT ELEANOR S. WATSON		ADDRESS SAME AS 13		WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10/25, 1979, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Kirkland O. Bruce				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIRKLAND O. BRUCE				22e. ADDRESS 7600 Carroll Ave, Takoma Park MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/4/79		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA		23e. REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR'S NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				24b. ADDRESS		25. DEC 6 1979		25b. REGISTRAR'S SIGNATURE Ricky McBratney			

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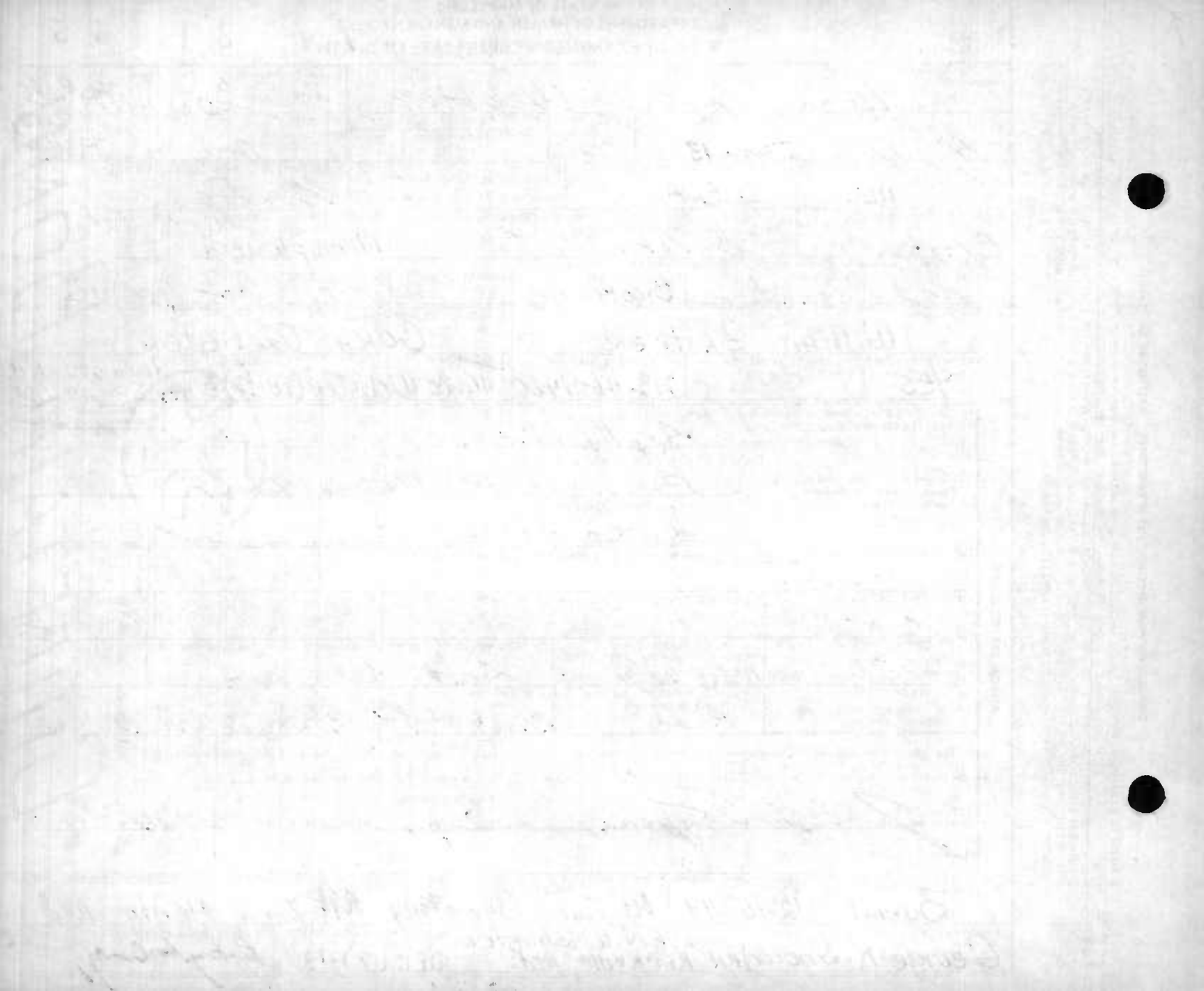
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- STATE REGISTRAR		REG. NO. 31455									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE OF DEATH	
Leon McCoy Webster								Dec 11 1979		11:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
M	BLK	June 13 46		33 YRS.						Dec 11 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.		WIDOWED		DIVORCED		Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Brookville		Brookville Rd						Unemployed			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md		Mont.		Brookville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19872 Mt. Zion Rd			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
William Gaither				CORA Webster							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
YES				213-46-9460				Joyce Webster (wife) 64 Norwood Rd. Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Asphyxiation</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Pressure on Ven on Chest</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Auto Accident</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
<u>None</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
<u>None</u>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
11:00 AM 12 11 1979				Auto Accident							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
				Road				Brookville Rd Brookville Mont Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE			
<u>George R. Snowden</u>				M.D. <u>Dep.</u>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
George R. Snowden				246 N. Washington Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY		23f. STATE	
Burial		12-15-79		Mt. Zion Cemetery		Mt. Zion		Montg		Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
George R. Snowden				DEC 17 1979				<u>George R. Snowden</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 4 5 6		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN			
SARAH		WEINER		12-29-79		10 ³⁵ A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR # UNDER 24 HRS	
Female		Cauc		2 22 98		81 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Russia		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Bethesda Nursing Center		Tailor		Clothing Mfg.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md.		Montgomery		Chevy Chase				2631 Colston Drive	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Shimshon Kaufman					Chaya Riva Goss				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		088-18-4416A		Robert H. Weiner, 2631 Colston Dr, Chevy Ch. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) this physician attended the decedent from 12/1 19 79 to 12/29 19 79, that (ii) the decedent died on 12/1 19 79, and that in my (oral) opinion death occurred on the date and hour and from the causes stated above. (If the decedent died before the body of the death.									
22b. SIGNATURE Ralph E. Seligmann				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH E. SELIGMANN MD.				22e. ADDRESS 8630 Fenton St. Sil. Spr., Md 20918					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 30, 1979		23c. NAME OF CEMETERY OR CREMATORY Judean		23d. LOCATION CITY OR TOWN Olney		COUNTY STATE Montgomery Md.	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg INC. 1170 Rockville Pk.				ADDRESS Rockville, Md.		25a. DATE REC'D. BY REGISTRAR JAN 2 1980		25b. REGISTRAR'S SIGNATURE	



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 4 5 7 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Anthony G. Weinlein				2a. DATE OF DEATH MONTH DAY YEAR 12.18.79				2b. HOUR 4 A M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR June 1, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7c. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secy/treasurer		12b. KIND OF BUSINESS OR INDUSTRY Union	
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6817 Tilden Lane, 20852	
14 FATHER'S NAME FIRST MIDDLE LAST Frank Weinlein				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Puerzer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W. W. 2		17 INFORMANT ADDRESS Mary E. Weinlein-Same as items #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic Heart Failure</u> (c) <u>Arterio Sclerotic Heart Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>2 year</u> <u>19 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>78</u> , to <u>12/18</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12/16</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Jack P. Segal</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12/18/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK P. SEGAL				22e. ADDRESS 5530 Wisconsin Ave Chevy Chase, Md 20015					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/21/79		23c. NAME OF CEMETERY OR CREMATORY Monocacy		23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville Mont. Md.			
24. FUNERAL DIRECTOR NAME W. W. ChambersCo., Silver Spring, Md.				25a. DEATH REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

Handwritten notes at the bottom of the page, including "12/21/72" and "Mississippi, Mont."

Handwritten notes in the middle section, including "Mississippi, Mont." and "12/21/72".

Handwritten notes in the lower middle section, including "Mississippi, Mont." and "12/21/72".

Handwritten notes in the upper middle section, including "Mississippi, Mont." and "12/21/72".

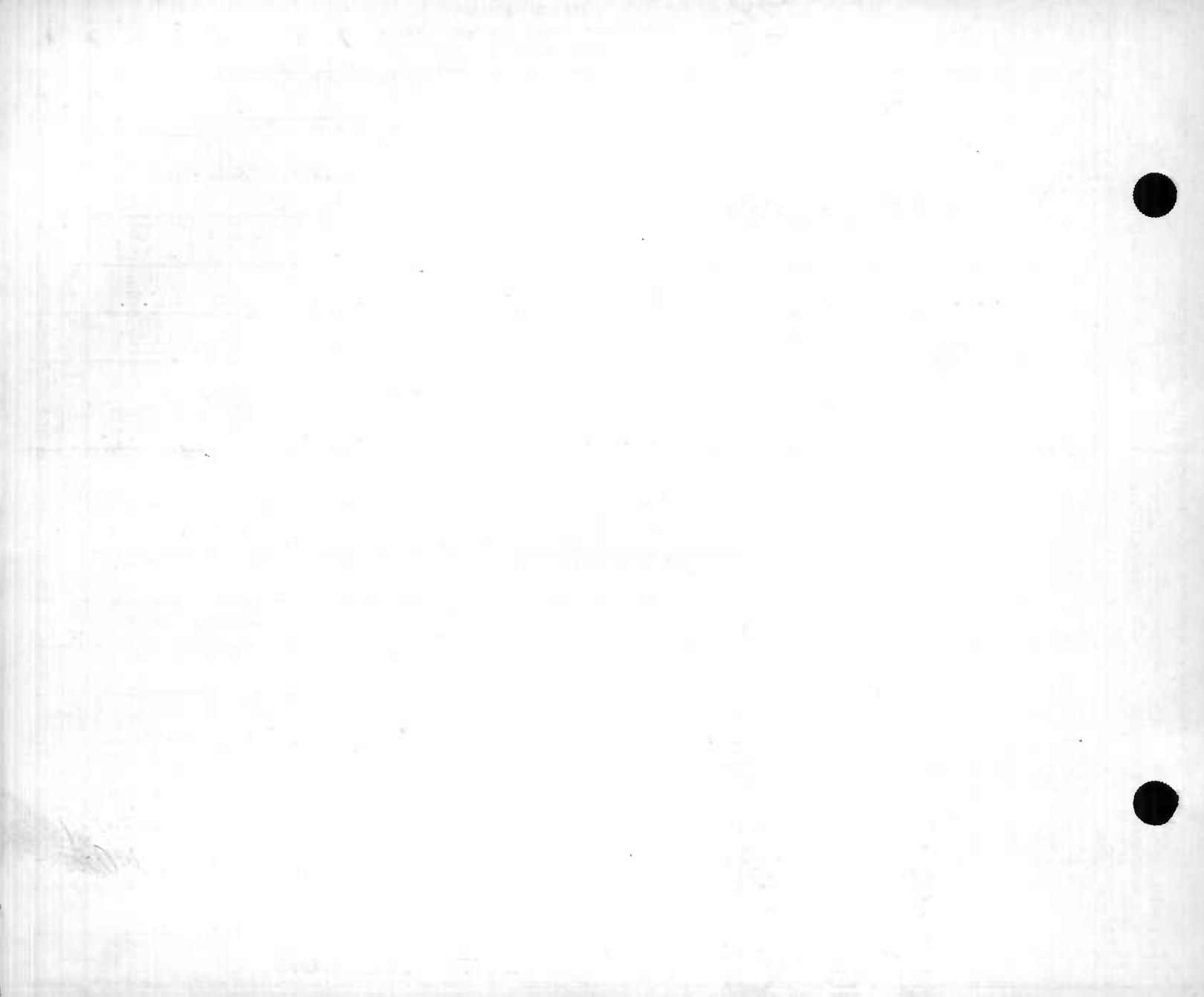
Handwritten notes at the top of the page, including "Mississippi, Mont." and "12/21/72".

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 4 5 8	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Arthur Eugene Weiseger			2a. DATE OF DEATH December 18, 1979			2b. HOUR 9:15 PM					
3. SEX Male		4. RACE Afro-American		5. DATE OF BIRTH March 5, 1941		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) District of Col.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman			12b. KIND OF BUSINESS OR INDUSTRY Private		
13a. STATE D.C.		13b. COUNTY ---		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1613 Varnum Street N.W.			
14. FATHER'S NAME James Arthur Weiseger				15. MOTHER'S MAIDEN NAME Ethel --- Sutton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 572-52-8531		17. INFORMANT ADDRESS Sherry G. Weiseger, wife, SAA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE 5829 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION 7 years DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC RENAL DISEASE 7 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/17/79 to 12/18/79, that (I) (we) last saw the deceased alive on 12/18/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did) (did not) view the body after death.											
22b. SIGNATURE Joel A. Priskin, MD				DEGREE				22c. DATE SIGNED 12/20/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel A. Priskin, MD				22e. ADDRESS 809 Vears Mill Rd, Rockville, MD 20851							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 22, 1979		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland					
24. FUNERAL DIRECTOR NAME McGuire Funeral Service, Inc., 7400 Ga. Ave. N.W.				25. DATE REC'D. BY REGISTRAR DEC 27 1979		25a. REGISTRAR'S SIGNATURE H. J. McCreedy					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN R WEITZEL			2a. DATE OF DEATH MONTH DAY YEAR 12 8 79			2b. HOUR 1:40 P.M.			
3 SEX MALE		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR DEC 7, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY ARMY DEPARTMENT		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4505 WESTBROOK LANE	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN B. WEITZEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE McAULIFFE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 217-42-8042		17 INFORMANT MARY K. WEITZEL			ADDRESS SAME AS 13 WIFE		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pneumonia</u> 185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>metastatic carcinoma of prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>generalized arteriosclerosis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (H) (his hospital) attended the deceased from <u>Dec 8</u> , 19 <u>79</u> , to <u>Dec 8</u> , 19 <u>79</u> , that (H) (we) lost saw the deceased alive on <u>Dec 8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22a. SIGNATURE W. R. Elzermantraut MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/9/79	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) W. R. Elzermantraut				22e. ADDRESS 11125 Rockville Pike, Rockville MD 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/12/79		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24 FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE T. J. McCreedy			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 4 6 0		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN			
OMER WELING				12/3/79		11:30 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
male		White		12 24 04		74 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Ohio		U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hospital		Division Chief		FAA-U.S. Gov't.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
md.		montgomery		Olney		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. ADDRESS					
Oliver		Welling		Lucy Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT					
No		579-58-1291		Kristin W Klingensmith, Dtr. Same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
436- Cardio-respiratory failure								12 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral vascular accident								14 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis/hypertension								10-4 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 26, 1979, to Dec 3, 1979, that (I) (we) last saw the deceased alive on Dec 2, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, do not view the body after death.)									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
JOHN M. WYMAN		MD				12/4/79			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12/6/1979		Norbeck Memorial Park		Olney, Maryland.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons Inc.		5130 Wisc. Ave N.W. Wash., D.C.		DEC 7 1979					

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• *Journal of Management Education* 25(1): 10-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 7 9 3 1 4 6 1					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES PATRICK WELSH					2a. DATE OF DEATH MONTH DAY YEAR 12 25 77					
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 16 04		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		2b. HOUR 6:40 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN				12. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY Government		
13a. STATE MD					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN DERWOOD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry - Welsh					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah Agatha Boyle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W. War II 218-34-6196		17. INFORMANT ADDRESS Mrs. Janet Snyder Welsh Derwood, Md. 20855						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Coronary atherosclerosis</u> (c) <u>Coronary atherosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Severe diabetes mellitus, renal failure, hypertension</u>										
19a. DATE OF OPERATION 12-26-77 12-23-77		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Myocardial revascularization by</u> <u>coronary artery bypass graft</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15-77</u> to <u>12-29-77</u> , that (I) (we) lost <u>saw the deceased alive on 12-29-77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Ruben C. Cosca, M.D.					DEGREE M.D.		22c. DATE SIGNED 12-29-77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ruben C. Cosca, M.D.					22e. ADDRESS 17529 Redland Rd., Derwood, Md. 20855					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, '80		23c. NAME OF CEMETERY OR CREMATORY Cheltenham Nat. Cem.		23d. LOCATION CITY OR TOWN Cheltenham, Prince Georges		STATE Md.		
24. FUNERAL DIRECTOR Gartner-Sandison F. H.					25a. DATE REC'D. BY REGISTRAR JAN 4 1980		25b. REGISTRAR'S SIGNATURE [Signature]			
26. ADDRESS 316 E. Diamond Ave., Gaithersburg, Md.										

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 6 2
REG. NO.

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)		FIRST MALCOLM	MIDDLE HARMAN	LAST WHITE	2a DATE OF DEATH MONTH DAY YEAR 12-6-79	2b HOUR 5:00P M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 4, 1899	6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.
10 CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL		12a USUAL OCCUPATION (IF DECEASED WAS SELF-EMPLOYED) Produce Broker Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farm				
13a STATE Maryland		13b. COUNTY Mont.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 3457 Chiswick Court			
14 FATHER'S NAME FIRST MIDDLE LAST Alton P. White		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret R. Harman						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-34-4838 A		17 INFORMANT ADDRESS Virginia A. White Same as #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 4289 IMMEDIATE CAUSE (a) Heart Failure - shock DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Lymphocytic Leukemia								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11-17, 19 79, to 12-6, 19 79, that (I) (we) last saw the deceased alive on 12-6, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Alberto Rotsztein				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-6-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERTO ROTSTEIN				22e. ADDRESS 3701 Rossmore Blvd Silver Spring, Md. 20906				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 10, 1979		23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.		
24. FUNERAL DIRECTOR NAME Francis H. Barber				ADDRESS Laytonsville, Md. 20760		25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

29

3203 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 3 1 4 6 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Blanche L. Whitney		2a. DATE OF DEATH MONTH DAY YEAR 12 21 '79		2b. HOUR 2 A	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 04 27 '84		6 AGE (IN YEARS LAST BIRTHDAY) 95 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Norwalk, Conn.	7b CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.	
10 CITY OR TOWN OF DEATH Cherry Chase	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Nursing Retirement	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Wash., D. C.		13b. COUNTY ---	13c. CITY OR TOWN Wash, D. C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3338 Military Road, N. W.
14 FATHER'S NAME FIRST MIDDLE LAST Robert L. Ells		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Carter		17. INFORMANT ADDRESS 3338 Military Road, N. W. Washington, D. C.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-92-7554			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5990 Chronic nonbacterial infectious atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO OR AS A CONSEQUENCE OF (b) Chronic nonbacterial infectious atherosclerosis DUE TO OR AS A CONSEQUENCE OF (c) Chronic thrombotic syndrome with prolonged stasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic thrombotic syndrome with prolonged stasis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. '79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from December 6, 1979 to December 19, 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE George L. Grant, Jr. M.D.		22c. DEGREE M.D.		22d. DATE SIGNED 12/21/79	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) George L. Grant, Jr. M.D.		22f. ADDRESS 6001 Arlington Road, Bethesda, Md. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-26-79		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25a. DATE RECEIVED BY REGISTRAR DEC 21 1979	
24. FUNERAL DIRECTOR 5130 Wisconsin Avenue, N. W. Washington, D. C. 20016		25b. REGISTRAR'S SIGNATURE Crady			

J. R. U.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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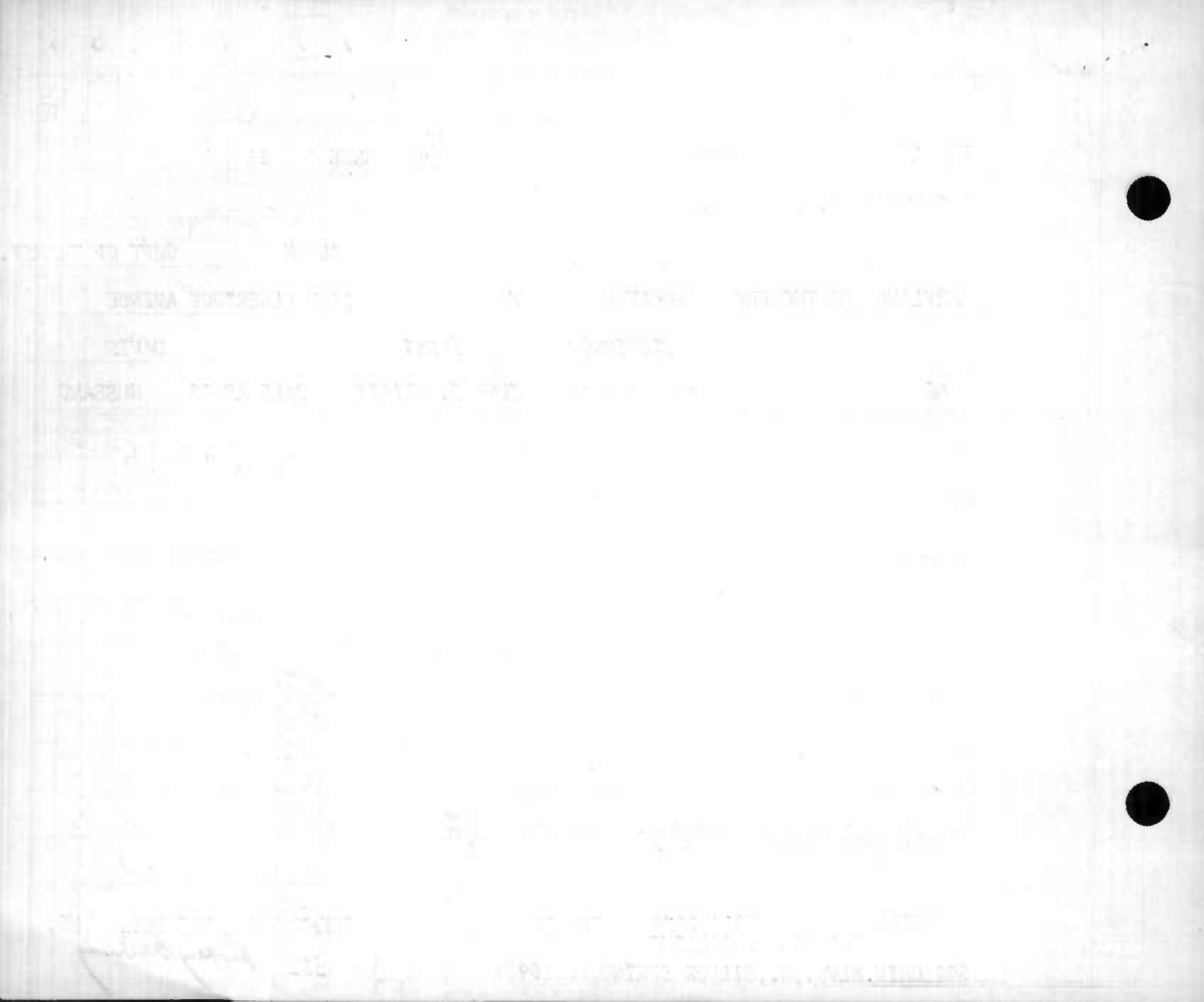
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					7 9 3 1 4 6 4				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR				
FIRST WILLIAM MIDDLE WRIGHT LAST WILLIFORD William WRIGHT Williford JR.					12 5 79 5PM				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 6 16 09		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? Amer. U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH TAKOMA PK.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADV. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Safety supervisor		12b. KIND OF BUSINESS OR INDUSTRY Phone Co.	
13a. STATE MD.		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Phone Co. 7609 Westfield Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST William W. Williford		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Schreiner							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-01-063		17. INFORMANT ADDRESS Mary Belle Williford, Wife. Same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4241 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) SEVERE AORTIC STENOSIS DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION Dec-5, 79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED SEVERE AORTIC STENOSIS				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from DEC. 3, 19 79, to DEC. 5, 19 79, that (I) (we) last saw the deceased alive on DEC. 5, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. Neimat, MD.		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-5-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. NEIMAT, MD-				22e. ADDRESS 831 University Blvd. E. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/8/1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland			
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Washington, D.C.				25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 4 6 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary D Willis</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>12-12-79</i>				2b. HOUR <i>7:55 AM</i>
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7-27-1913</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>66 YRS</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASHINGTON, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CLERK</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>DEPT OF TRANSP.</i>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i>				13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>WHEATON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>DICKINSON</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>JESSIE DAVIS</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>577-58-3071</i>		17. INFORMANT <i>JUNE J. WILLIS</i>		ADDRESS <i>SAME AS 13 HUSBAND</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asphyxiation</i> <i>7882</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Asphyxiation</i> (c) <i>Asphyxiation</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>48 hrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Cerebral Arterio Sclerosis</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>7/15</i> 19 <i>75</i> , to <i>12/12</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>12/11</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <i>Richard Cioffi</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>12/12/79</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R Cioffi</i>				22e. ADDRESS <i>10620 Georgia Ave SS MD</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>DEC 14, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BRENTWOOD PRI GEO MD.</i>		
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>				25a. DATE REC'D. BY REGISTRAR <i>DEC 17 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Richard Cioffi</i>		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901								



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Virginia C. Wilson				12 12 79		7:50 ^a AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucasian		MONTH DAY YEAR 5 28 12		67 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New Jersey		USA				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		9101 Second Ave., Silver Spring, MD		10611 SWEETBRIAR PARKWAY		U.S. GOVERNMENT			
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
Maryland		Montgomery		YES <input type="checkbox"/> NO <input type="checkbox"/>		XXXXXXXXXXXXXX			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			
John F. Clarke		Katherine A. Duffy		NO		979-44-8674			
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningeal sarcoma of the brain</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiac arrest due to cerebral anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypoxia</u>		19. ADDRESS		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
John F. Clarke Jr.				10511 Sweet Briar Pkwy. Silver Spring, MD		105 -			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>FALL</u> , 19 <u>70</u> , to <u>12/12</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Robert H. Grollman MD</u> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT H. GROLLMAN MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/12/79</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>12/14/79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>ARLINGTON VIRGINIA</u>		23e. DATE REC'D. BY REGISTRAR <u>DEC 17 1979</u>	
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> <u>500 UNIV. BLVD. W. SILVER SPRING, MD. 20901</u>		25. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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9. 01. 2011

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1990-1991 111 1991-1992 111

VALLEY CENTER, ILL.

1. The first part of the paper is devoted to the study of the properties of the function $f(x)$ defined by the equation

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82-1054

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 4 6 7

1 - FOR
STATE
REGISTER

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Suandi L. Winardi			2a. DATE OF DEATH MONTH DAY YEAR Dec. 9, 1979		2b. HOUR 2:30 P.M.
3. SEX Male	4. RACE Yellow	5. DATE OF BIRTH MONTH DAY YEAR Oct. 9, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indonesia	7b. CITIZEN OF WHAT COUNTRY? Indonesia	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10312 Fleming Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stocks & Bonds Investment		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Brazil			13b. COUNTY	13c. CITY OR TOWN Sao Paulo	
14. FATHER'S NAME Gwat Loen			15. MOTHER'S MAIDEN NAME Tjoe Nio Thio		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Horace Darmawi	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>RENAL CARCINOMA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1890</u> HOURS <u>1</u> MONTHS <u>1</u> YEAR					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>5/24</u> , 19 <u>79</u> , to <u>12/9</u> , 19 <u>79</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12/8</u> , 19 <u>79</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> did not view the body after death.					
22b. SIGNATURE <u>Daniel Rosenblum</u>		DEGREE <u>MD</u>		22c. DATE SIGNED 12/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Rosenblum, M.D.		22e. ADDRESS 10400 Conn. Ave. Kensington, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 17, 1979	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND		25a. DATE REC'D. BY REGISTRAR DEC 20 1979			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



01/04/2002

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 mg-1 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

added info 539 1/16/80 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

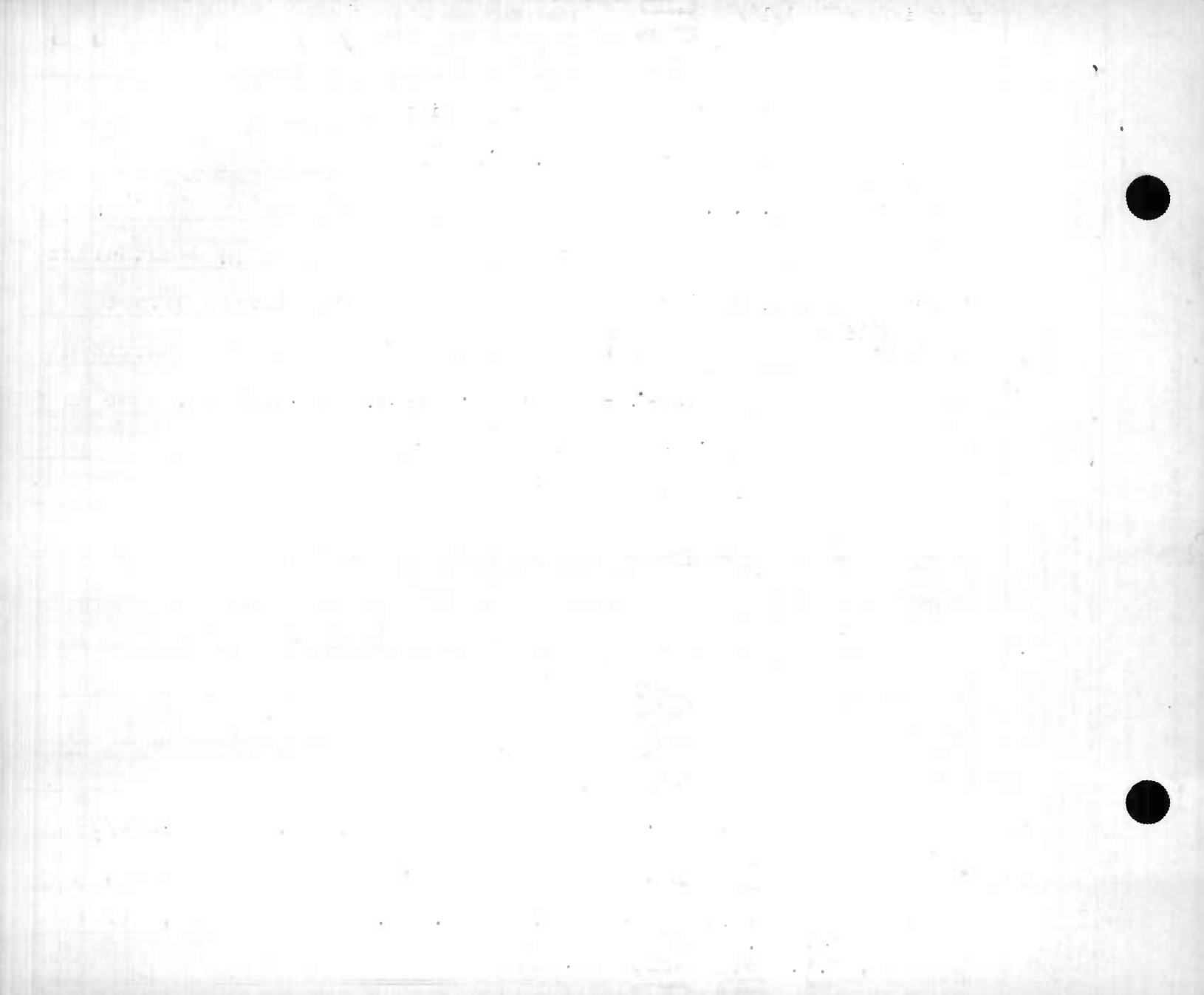
3 1

4 6 8

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WILLIAM Harrison WITT Witt			2a. DATE OF DEATH MONTH DAY YEAR 12 6 79			2b. HOUR MIN 1 30				
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 28, 1926		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 53		7. IF UNDER 1 YEAR MONTHS DAYS 53		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Red Ash Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Worker in		12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. STREET ADDRESS 514 Lincoln Street	
14. FATHER'S NAME FIRST MIDDLE LAST Willian Sanders Whitt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosey Rosa Katherine Harrison							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 223-30-0481		17. INFORMANT ADDRESS Rosey Katherine Harrison, Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Pancreas DUE TO, OR AS A CONSEQUENCE OF (c) 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10-22 19 79 , to 12-6 19 79 , that (I) (we) last saw the deceased alive on 12-5 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Carol Bender			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol Bender			22e. ADDRESS 11125 Rockville Pike Rockville, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/9/79		23c. NAME OF CEMETERY OR CREMATORY Greenville Mem. Gar.			23d. LOCATION CITY OR TOWN COUNTY STATE Claypool Hill, Virginia		
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE RECEIVED BY REGISTRAR DEC 12 1979				

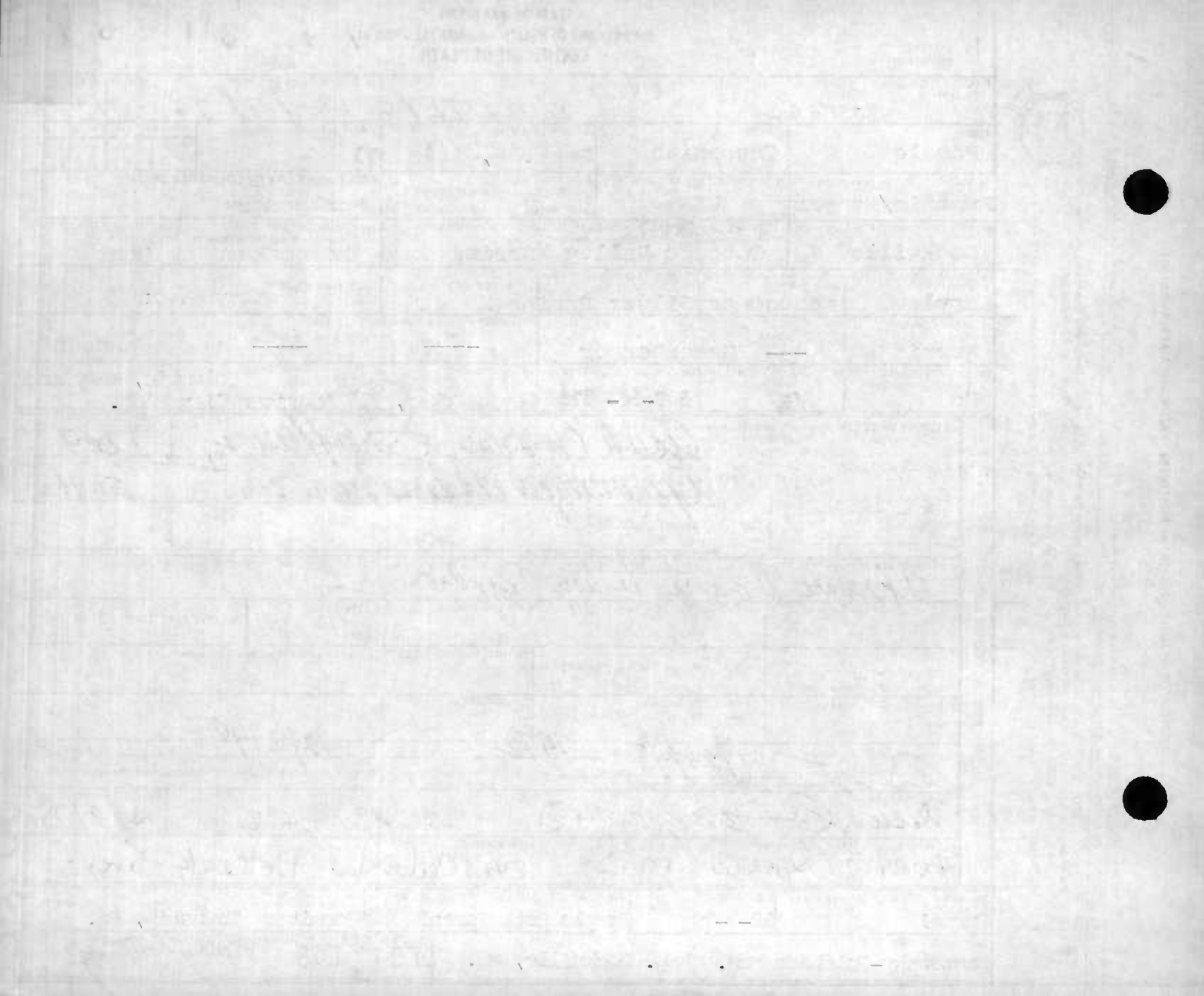


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 7 9 3 1 4 6 9							
1. DECEASED NAME (TYPE OR PRINT) <i>Grace WOLLTER</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12/31/79</i>		2b. HOUR <i>1:13 A.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 28, 1888</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Austria/Hungary</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Potomac Valley Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Silver Spring</i> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					13e. STREET ADDRESS <i>8105 Eastern Avenue</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Morris Greenberger</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>N/A</i>		17. INFORMANT <i>David Scher</i>		ADDRESS <i>Columbia, Maryland City Bldg.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i> 411 - DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Atherosclerosis</i> 204P8 DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 DAY</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Chronic Organic Brain Syndrome</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. certify that (I) (this hospital attended the deceased) from <i>11/25/79</i> 19 <i>1972</i> , to <i>12/31/79</i> 19 <i>1979</i> , that (I) (we) lost saw the deceased alive on <i>11/25/79</i> 19 <i>1972</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Henry C. Scruggs</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>12/3/79</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Henry C. Scruggs M.D.</i>				22e. ADDRESS <i>5413 Cedar La. Bethesda Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-5-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Temple Beth Israel</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hermitage Township, Pa.</i>			
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Mem. Chap.</i>				ADDRESS <i>Rockville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 11 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

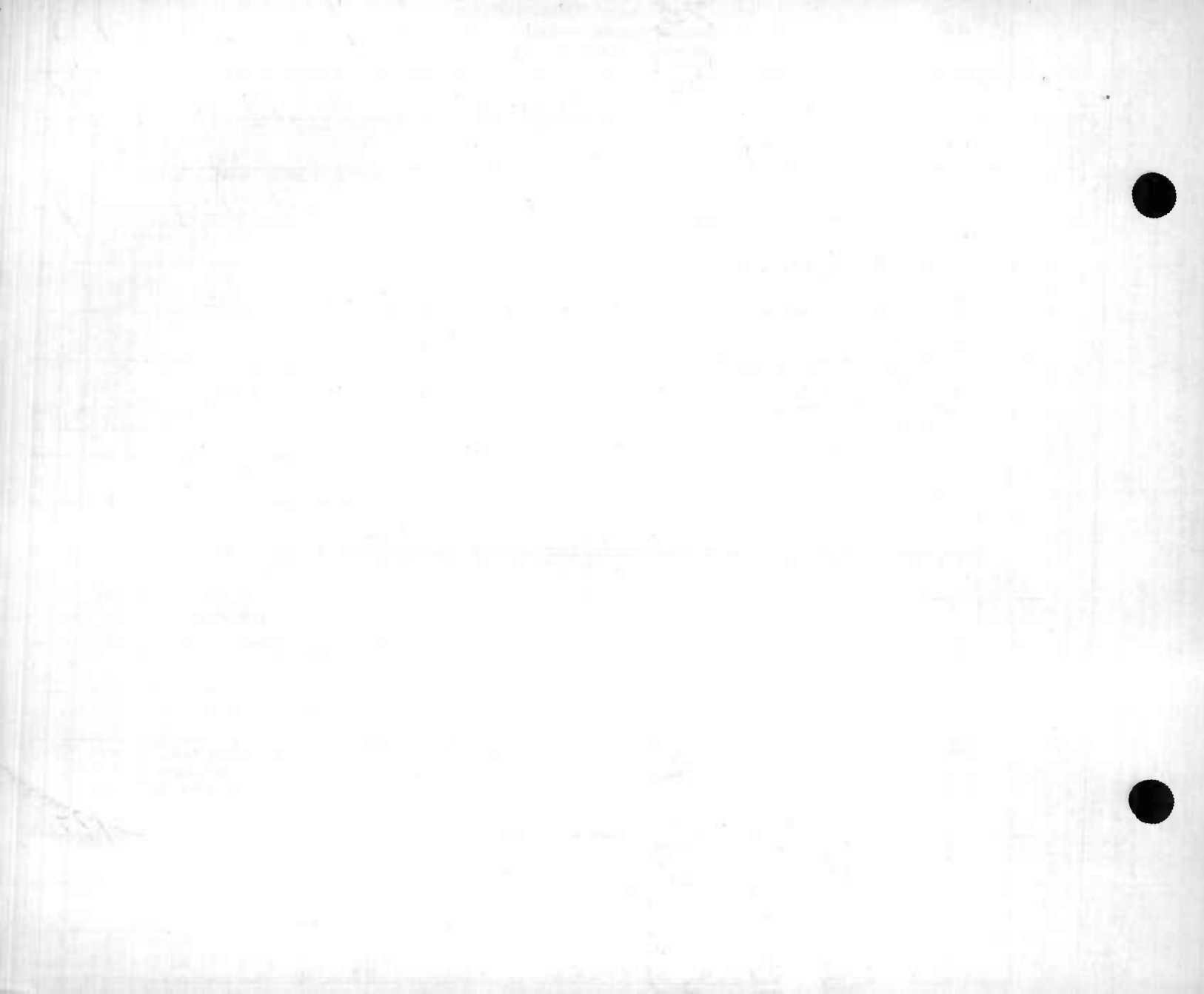


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 79 31470									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Cyril G. Wright								12-11-79		3P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
Male		White		Aug. 15, 1902		77					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
England		USA				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital						Carpenter		Retired	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		MONTGOMERY		Silver Spring				3006 Weisman Road			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Arthur Wright				Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		3006 Weisman Road					
Yes		WWI		577-10-6277A		Ruth Meiklejohn Silver Spring, Md. 20902					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Hyperkalemia & cardiac arrest</u>										12 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u>										6 mos	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of Colon</u>										1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/12/77</u> to <u>12/11/79</u> , that (I) (we) last saw the deceased alive on <u>12/11/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
S. N. Jones, M.D.								12/14/79			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Dec. 14, 79		Parklawn Cemetery		Rockville, Montgomery, Md.					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hines/Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md.						DEC 14 1979		Ruth Meiklejohn			



STATE OF MARYLAND		9 3 1 4 7 1	
FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST		MONTH DAY YEAR	
Kum Chor Wu		12-29-79 8:20 PM	
3. SEX		4. RACE	
Male		Chinese	
5. DATE OF BIRTH		6. AGE (IN YEARS)	
MONTH DAY YEAR		LAST BIRTHDAY YRS.	
April 9, 1921		58	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Canton, China		Republic of China	
8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
WIDOWED NEVER MARRIED		Montgomery MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Bethesda		Suburban Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Ret. Business man		Restaurant	
13a. STATE		13b. COUNTY	
Md.		Montgomery	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Rockville		YES NO	
13e. STREET ADDRESS		13f. STREET ADDRESS	
4800 Wyaconda Road		4800 Wyaconda Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST		FIRST MIDDLE LAST	
Unknown		Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
YES NO, OR UNKNOWN		17. INFORMANT	
No		Rockville, Md. 20852	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION	
PART I DEATH WAS CAUSED BY:		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
IMMEDIATE CAUSE (a) <u>Cerebral Insufficiency Acute</u>		20. AUTOPSY?	
DUE TO, OR AS A CONSEQUENCE OF		YES NO	
(b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.</u>		YES NO	
DUE TO, OR AS A CONSEQUENCE OF		YES NO	
(c) <u>411-</u>		YES NO	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	
21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
HOUR A.M. MONTH DAY YEAR		P.M. 19	
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
NOT WHILE AT WORK		21f. LOCATION	
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner		22b. NAME OF CEMETERY OR CREMATORY	
John G. Ball, MD		George Wash. Cemetery	
22c. DATE		22d. LOCATION	
Jan. 13, 1980		Adelphi, Maryland	
22e. NAME OF CEMETERY OR CREMATORY		22f. LOCATION	
George Wash. Cemetery		Adelphi, Maryland	
22g. DATE REC'D. BY REGISTRAR		22h. REGISTRAR'S SIGNATURE	
JAN 11 1980		John G. Ball, MD	
22i. FUNERAL DIRECTOR		22j. DATE REC'D. BY REGISTRAR	
J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., D.C. 20002		JAN 11 1980	
22k. DATE REC'D. BY REGISTRAR		22l. REGISTRAR'S SIGNATURE	
JAN 11 1980		John G. Ball, MD	

J. L. Hines & Sons Co. 300-4th St., E., Wash., D.C. 20002

Jan. 19, 1950 George Wash. Cemetery, Meland, Maryland

John G. Bell, MD Bethesda, Maryland

None 217-92-2092

Tim Chenn, co-son 4800 Wyanona St.,
Rockville, Md. 20852

Unknown

Unknown

Mr. Montgomery Rockville

4800 Wyanona Road

Rockville

Ret. Business man Restaurant

Ganton, China

Male Chinese April 2, 1941 58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										7	9	3	1	4	7	2
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Hyman Zalkind</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>12-17-1979</i>				2b. HOUR <i>1:45 A.M.</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 23, 1189</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.									
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Routeman</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i>							
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>8101 16th Street</i>						
14. FATHER'S NAME FIRST MIDDLE LAST <i>Avrum Zalkind</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Reza (unknown)</i>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>								
16a. SOCIAL SECURITY NO. <i>578-07-4759</i>				17. INFORMANT ADDRESS <i>Falls Church, Va. Caroline Lossef; 3701 S. Geo. Mason Drive</i>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSION, RESPIRATORY & RENAL FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>SEPSIS</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>3 days</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>DIABETES MELLITUS</i>																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <i>12/12</i> , 19 <i>79</i> , to <i>12/17</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>12/16</i> , 19 <i>79</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>R. Rosenberg</i>				DEGREE <i>M.D.</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/17/79</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT L. ROSENBERG, MD.</i>				22e. ADDRESS <i>6121 MOUNTAIN RD, ROCKVILLE, MD. 20862</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-20-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Beth Shalom Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Capitol Heights, Maryland</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 24 1979</i>						
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i>				ADDRESS <i>Rockville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>										

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF THE DEATH IS SUSPECTED TO BE A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMM - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31473

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Juliana R. Zarou				12 18 79		12 18 79	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR
15	W	9 30 60	19 YRS.			12 18 79	12 18 79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Jordan		USA				Montgomery MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hosp		never employed		--	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS			
Maryland		Montgomery		Rockville		520 Bradford Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Rebhi B. Zarou		Nada Rabie					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		n/a		Rebhi B. Zarou same as 13c			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Acute Respiratory Arrest</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							
(b) <u>Grand Mal Seizure</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE		DATE	
John Rogers		M.D. Asst. Medical Examiner		12/18/79			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Rd. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		12/20/79		Gate of Heaven Cemetery		Silver Spring, Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home, Inc.		12/28/79					
1331 Rockville Pike		Rockville, Md.					

DEC 28 1979



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31474	
1- FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		2b. HOUR	
		FIRST		MIDDLE		LAST		MONTH		DAY	
		ARGYRO				ZGURIS		12-26		1979	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
female		white		Feb. 25, 1920		59 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Greece		U.S.A.				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital						Seamstress		Self-Employed	
13a. STATE				13b. CITY OR TOWN		13c. CITY LIMITS?		13d. STREET ADDRESS			
Md.				Montgomery		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12918 Georgia Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Kostas				Kolios				Sophia Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				None		086-32-3502		Mrs. Glykeria Dickson		Charlottesville, VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY 6:15 PM 12-26 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
						pedestrian struck by auto					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY					
				street		Georgia Ave. & Hathaway Drive Silver Spring, Md.					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
				Assistant				12/27/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Ann M. Dixon, M.D.				111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				12/30/1979		Woodlawn Cemetery		Hamilton Madison		N.Y.	
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
E. Barnes Fleming Funeral Service - Benson, Md.						DEC 31 1979					

